Perceptions of recovery from mental health difficulties, and associated factors

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Abstract

Literature Review:A systematic review of findings from 14 studies investigating patients' and clinicians' perceptions of, and factors associated with, recovery from depression. Recovery from depression is perceived as a complex, personal journey, influenced by a range of factors. The concept of normalised, biomedical definitions of recovery is not supported, whilst construction of self and societal gender expectations are identified as central to recovery. Recovery from depression was associated with higher levels of perceived social support and group memberships. However, significant differences emerged betweenclinicians' and patients' perspectives of what is important in being in recovery from depression. Clinical implications and recommendations for future research are outlined.

Empirical Report: Recent research has identified differences between clinicians' and patients' perspectives of what is important in being in recovery from depression. The present study thereforeaimed to further investigate clinicians' perceptions of patient recovery from mental health difficulties. Template analysis of 17 interview transcripts yielded five superordinate themes relating to: initial session 'wants'; defining 'recovery'; the meaning of 'recovery' to patients; personal qualities beneficial for promoting recovery; and barriers to recovery. Participants perceived recovery as a complexprocess, influenced by multiple factors. Participants consistently identified a range of tensions and complexities relating to service definitions of recovery, preferring to use alternative, clinically-based definitions of recovery. Findings are discussed in relation to the existing literature, with recommendations made for future research and clinical implications considered.

Acknowledgements

I would like to thank the managers and therapists who endorsed this project and gave up time to share their views on recovery.Without your input, this study would not have been possible. I also want to thank my research supervisor, Professor Michael Barkham, and Janice Connell for their support and guidance, and Professor Glenn Waller and Dr Andrew Thompson for stepping into the breach at short notice. Last but no means least, thank you to my family and friends for their unwaveringsupport and encouragement.

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Section One: Literature Review

Perceptions of, and factors associated with, recovery from depression:

A systematic review

Abstract

Objectives

Despite extensive literature examining perceptions of recovery from severe mental illness, there is limited literature focusing on recovery from depression in adults. To date, there has been no systematic review of the existing literature. This review therefore summarises the existing literature investigating patients' and clinicians' perceptions of, and factors associated with, recovery from depression.

Method

A search of eight databases, including PubMed, PsychINFO, and ScienceDirect, was conducted to identify studies investigating perceptions of, and factors associated with, recovery from depression in adults. Studies were assessed against inclusion criteria and quality rating checklists.

Results

Fourteen studies met the inclusion criteria (five quantitative, nine qualitative). Recovery from depression is perceived as a complex, personal journey. The concept of normalised, biomedical definitions of recovery is not supported, with construction of self and societal gender expectations identified as central to recovery. Recovery from depression was associated with higher levels of perceived social support and group memberships. A range of factors are identified as influencing recovery. However, clinicians' and patients' perspectives differ significantly in terms of what is important in being in recovery from depression.

Conclusions

Recovery from depression is perceived by patients as a complex, personal process that is influenced by a range of factors. However, greater understanding of

clinicians' perceptions of client recovery from depression is essential to inform clinical practice and influence future research.

Practitioner Points

Clinical implications

- Clinicians working with adults experiencing depression should be aware that recovery from depression is a complex process, consisting of multiple facets.
- Clinicians should be aware that symptom-based definitions of recovery based on routine depression measures do not necessarily indicate recovery according to patient perspectives.
- Clinicians should be aware of the potential impact of societal gender expectations in maintaining or exacerbating patients' depression, and of the positive associations between increased self-care, self-agency and recovery.
- The positive impact of social support and benefits of group membership in terms of protecting against, and assisting recovery from, depression should also be noted.

Cautions or limitations

- There are methodological weaknesses across the studies included in this review, including issues of generalisability and limited replication of findings, which limit the strength of the conclusions drawn.
- A lack of research was identified relating to practitioners' perceptions of patient recovery from depression, and this should be a focus of future research.

Depression: Definition, Prevalence and Burden

Depression is a mood disorder characterised by persistent feelings of sadness, hopelessness, and a loss of interest in previously enjoyed activities. For a diagnosis of major depressive disorder (MDD), the Diagnostic and Statistical Manual (DSM) of Mental Disorders (DSM-5; American Psychiatric Association, 2013) requires the presence of depressed mood or a loss of interest or pleasure in daily activities for more than two weeks. The depressed mood must represent a change from the individual's baseline, resulting in impaired functioning. Presence of five (minimum) out of nine specific symptoms is also required, nearly every day.

Recent global prevalence estimates indicate that approximately 98.7 million people worldwide are affected by depression. Lifetime prevalence estimates for depression vary from 8-12% of the adult population (Ustun, Ayuso-Mateos,Chatterji, Mathers, &Murray, 2004), with 12-month prevalence estimates ranging between 3% and 6% (Judd &Akiskal, 2000).Epidemiological researchusingdata from six European countries also indicates greater prevalence of depression amongst women (8.75%) than men (5.01%), with marked gender differences for MDD persisting across all age groups (Angst, et al., 2002).

Research published by the World Health Organisation (WHO) has identified depression as the leading cause of disability, with a 50% greater burden of depressionfor females than males (WHO,2008). Associations between depression and physical health have also been demonstrated, with depression having more damaging long-term effects on health and well-being than angina, arthritis, asthma, and diabetes (Moussavi, et al., 2008). The economic burden of depression in England alone was estimated at £9bn in 2000 (Thomas & Morris, 2003), compared

with estimated economic burdens of schizophrenia of £6.7bn (Mangalore & Knapp, 2007), and bipolar disorder of £2.1bn (Das Gupta & Guest, 2002).

Depression Rating Scales

A range of depression rating scales exist to establish the presence of depression and provide an indication of depression severity. These scales can be completed by researchers, clinicians and/or patients. For example, the Hamilton Depression Rating Scale (Hamilton, 1967; 1986) is a 21-item scale completed by clinicians, who select appropriate responses after interviewing patients and observing their symptoms. In comparison, the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, &Erbaugh, 1961)and the Centre for Epidemiologic Studies-Depression Scale (Radloff, 1977) are self-report inventories that cover a range of biological and affective symptoms of depression. The scales are completed by patients to identify the presence and severity of symptoms consistent with DSM diagnostic criteria for depression. Depression rating scales can be used to monitor the effects of both psychological and pharmacological treatments.

Recovery

The concept of recovery within mental health is contested, with multiple definitions of the term ‘recovery’ (Bonney &Stickley, 2008). Whilst the recovery model itself emphasises concepts such as hope, meaning and sense of self (Dickens, 2009), up to 16 core elements of recovery have been identified (Onken, Craig, Ridgway, Ralph & Cook, 2007). Furthermore, Slade (2012) distinguishes between clinical recovery and personal recovery. He proposes that clinical recovery focuses on professional imperatives, whilst personal recovery is more

ideological and focuses on social support and connectedness; hope and optimism; identity; meaning and purpose; and empowerment.

One limitation of the recovery literature is that perceptions of recovery are generally confined to recovery from schizophrenia and psychosis (Bonney &Stickley, 2008). Factors found to hinder recovery from these conditions include social exclusion, discrimination,inaccessibility to work, and economic hardship (Coleman, 1999;Sayce, 2000). Whilst these factors might equally hinder patients' recovery from depression, there is currently no existing review that investigates perceptions of, and factors associated with, recovery from depression.

Aims of Present Review

The present review aimed to synthesise the existing literature investigating patients' and clinicians' perceptions of, and factors associated with, recovery from depression in adults. As existing literature has indicated a greater incidence of depression amongst women than men, and identified social exclusion as a factor hindering recovery from mental illness, this paper systematically reviewed the available literature to:

1) Examine whether perceptions of recovery from depression differ according to gender.
2) Investigate the impact of perceived social support on recovery from depression.
3) Examine patients' and clinicians' perspectives of recovery from depression and factors associated with recovery.

Method

Search Strategy

Searches of the following databases were conducted (all years to 23rd September 2015): Cochrane Library; MEDLINE, PsycARTICLES; PsycINFO; Pubmed; ScienceDirect; Scopus; and Web of Knowledge. The Boolean operator "AND" was used to search combinations of the following search terms: (i) defin*, defining, definition; (ii) depression; (iii) perception, perspective, view; and (iv) cure*, recov*, recovered, recovery.

In addition to the database searches, the reference lists of full-text articles assessed for eligibility were also searched to identify any relevant studies that were not identified through database searches.

Screening and Selection

Figure 1 illustrates the search process. After initial database searches, 1737 records were identified, of which 1682 were excluded on the basis of title. Primary evaluation of 55 abstracts and titles led to a further eight records being removed on the basis of duplication. Manual searching of reference lists identified three records for inclusion in assessment for eligibility, bringing the total number of full-text articles assessed for eligibility to 50. Following assessment for eligibility, 36 papers were excluded on the basis of not meeting the inclusion criteria.

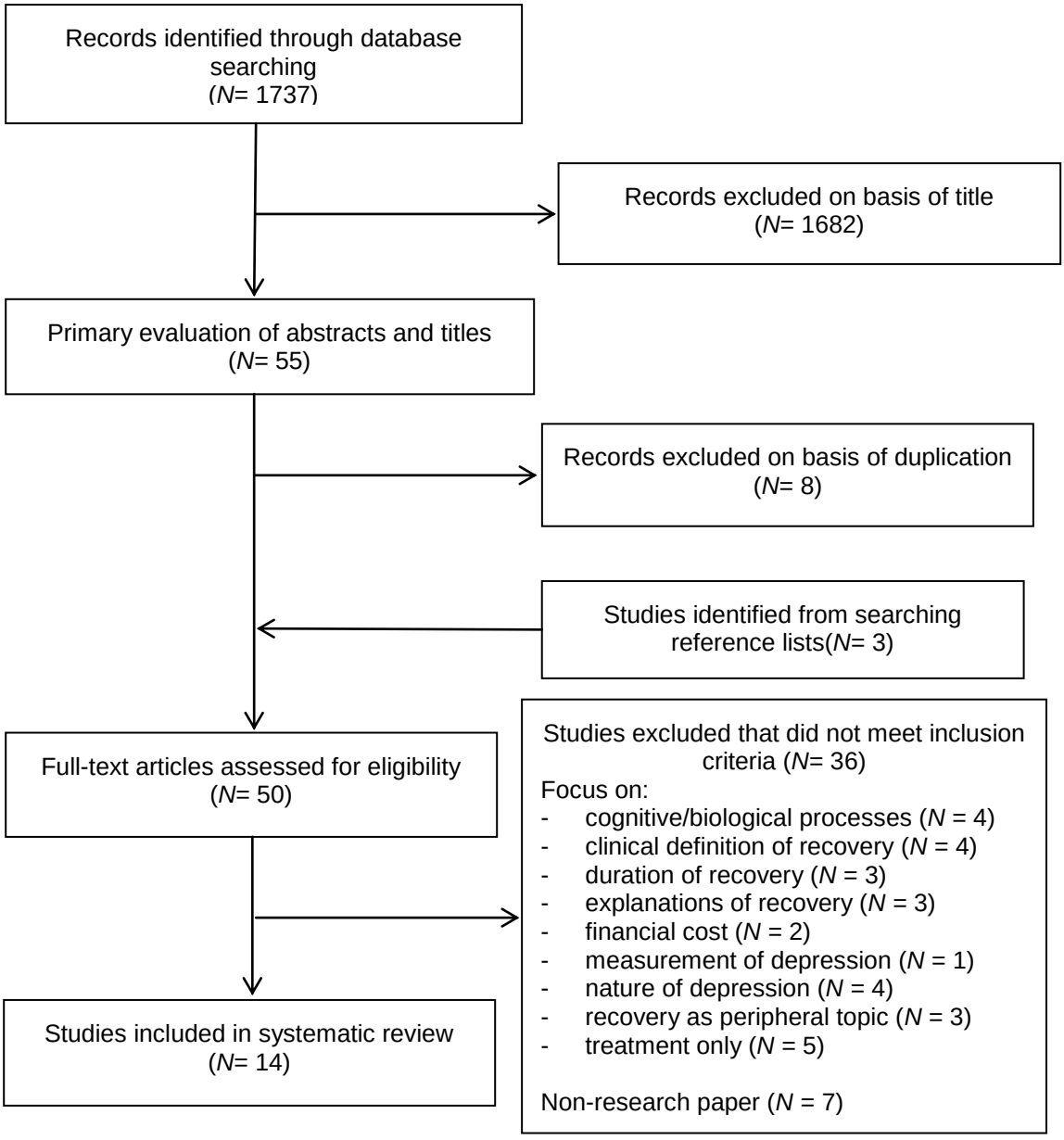

*Figure 1.*PRISMA flow diagram of study selection.

Inclusion/Exclusion Criteria

Research papers written in English, published in peer-reviewed journals, and with a focus on depression in adults aged 18+ were included. Records were excluded on the following basis: (i) focus oncognitive/biological processes involved in depression; (ii) focus on clinical definitions of recovery; (iii) focus on the duration of recovery; (iv) focus on explanations of recovery; (v) focus on the financial costs

associated with depression; (vi) focus on measurement of depression; (vii) focus on the nature of depression; (viii) recovery as peripheral topic; (ix) focus on treatment of depression only; and (x) non-research paper.

Quality Appraisal

The 14 studies identified as meeting the inclusion criteria were subsequently assessed against quality control checklists to ensure they were of sufficient quality (see Table 1). The QualSyst checklists (Kmet, Lee, & Cook, 2004) were used to assess the methodological quality of the studies.

Quality appraisal of quantitative studies. Quantitative studies are assessed using 14 criteria (see Appendix 1), with a total possible sum of 28 points available. A total sum score is calculated by allocating scores of two points for each criterion that is met and one point for partially met criteria. For nine criteria, there is an option of ‘not applicable’. A total possible sum is then calculated by multiplying the number of ‘not applicable’ criteria by two and subtracting the result from 28. The summary score is then calculated by dividing the total sum by the total possible sum.

Quality appraisal of qualitative studies. Qualitative studies are assessed using ten criteria (see Appendix 2), with a total possible sum of 20 points available. A total sum score is calculated by allocating scores of two points for each criterion that is met and one point for partially met criteria. The total sum is then divided by 20 to obtain a summary score.

Independent verification of quality ratings. Three papers were selected at random to be rated by an independent assessor, who was a postgraduate in social sciences. Inter-rater reliability was good (Kappa = .79, p = .001; Peat, 2002),

with discrepancies in scoring discussed until agreement was reached. The QualSystassessment criteria recommend the exclusion of papers obtaining a quality rating score that is <.75 of the total possible score. All papers scored above this cut-off point (Table 1), indicating at least moderate quality, and were therefore all included in the systematic review.

Table 1.

Characteristics of studies included in review (see footnote for definitions of abbreviations)

Author(s) and year	Study aims	Design and sample	Measures	Quality rating	Included (Y/N)
George, Blazer, Hughes, & Fowler (1989)	To investigate the effects of social support on the outcome of MD	Cross-sectional design 150 inpatients (77 aged 35-50 years; 73 aged 60+ years)	• CES-D • Duke Depression Evaluation Schedule for the Elderly • Duke Social Support Index (Landerman, George, Campbell, & Blazer, 1989) • Clinical interview	18/22 .82	Y
Brugha, Bebbington, MacCarthy, Wykes, & Potter (1990)	To consider the relation between social support and recovery from depression	Prospective, cross-sectional design 130 patients attending outpatient and emergency clinics	• Eysenck Personality Questionnaire (Eysenck & Eysenck, 1975) • Clinical interview • Interview Measure of Social Relationships (Brugha, et al., 1987)	18/22 .82	Y
Schreiber (1996)	To examine the process of recovery for women who have been depressed	Qualitative study 21 females; aged 32-69 years	• Researcher-developed: semi-structured interview schedule	16/20 .8	Y

Author(s) and year	Study aims	Design and sample	Measures	Quality rating	Included (Y/N)
Brown, Schulberg, &Prigerson (2000)	To investigate factors associated with symptomatic improvement and recovery from MD in primary care patients	Experimental design 181 primary care patients	• HRSD • Diagnostic Interview Schedule and SCID-II • Duke Severity of Illness Scale (Parkerson, Broadhead, &Tse, 1993) • Global Assessment Scale (Endicott, Spitzer, Fleiss, & Cohen, 1976) • Health Locus of Control Scale (Wallston, Wallston, Kaplan, &Maides, 1976) • Psychiatric Epidemiology Research Interview (Dohrenwend, Askenasy, Krasnoff, &Dohrenwend, 1978) • Interpersonal Support Evaluation List (Cohen, Mermelstein, Kamarck, &Hoberman, 1985)	21/26 .81	Y
Badger & Nolan (2005)	To understand the factors to which primary care patients attribute recovery from depression	Qualitative study 60 primary care patients; aged 24-68 years	• Researcher-developed: semi-structured interview schedule	17/20 .85	Y
Emslie, Ridge, Ziebland, & Hunt (2005)	To explore associations between depression and men's gender identities	Qualitative study 16 males; aged 30-75 years	• Researcher-developed: semi-structured interview schedule	18/20 .9	Y
Vidler (2005)	To understand women's experience of depression	Qualitative study 22 females; aged 22-75 years (recruited from the Longitudinal Investigation of Depression Outcomes study)	• Researcher-developed: semi-structured interview schedule • CES-D	19/20 .95	Y

Table 1 - *continued*

Author(s) and year	Study aims	Design and sample	Measures	Quality rating	Included (Y/N)
Gladstone, Parker, Malhi, & Wilhelm (2007)	To investigate perceived multidimensional social support in adult patients with MD	Cross-sectional design 218 patients attending outpatient clinics	• HDRS • Researcher-developed: self-report questionnaire assessing 'stressfulness' of life events and factors impacting on depression treatment • Beck Depression Inventory (Beck, et al., 1961) • Multidimensional Scale of Perceived Social Support (Zimet, et al., 1988) • Clinical interview	18/22 .82	Y
Johnson, Gunn, &Kokanovic (2009)	To examine recovery from depression from patients' perspectives	Qualitative study 576 primary care patients; aged 18-75 years	• Researcher-developed: structured interview schedule • CES-D	15/20 .75	Y
O'Brien (2012)	To critically examine mid-life women's recovery from depression	Qualitative study 31 females; aged 35-49 years	• Researcher-developed: semi-structured interview schedule	16/20 .8	Y
Cruwys et al. (2013)	To investigate the effect of group memberships on depression symptomatology over time	Cross-sectional/longitudinal design Adults enrolled in the English Longitudinal Study of Aging (proximal (N=5055) and distal (N=4087) samples)	• CES-D • Single item question assessing group membership	20/22 .91	Y

Author(s) and year	Study aims	Design and sample	Measures	Quality rating	Included (Y/N)
Fullagar& O'Brien (2014)	To examine how women construct meaning about recovery from depression through self-carepractices	Qualitative study 31 females; aged 35-49 years	• Researcher-developed: semi-structured interview schedule	15/20 .75	Y
van Grieken et al. (2014)	To explore patients' perspectives on how treatment can impede their recovery from depression	Qualitative study 27 patients; aged 22-63 years	• Researcher-developed: semi-structured interview schedule • SCID-II	16/20 .8	Y
Demyttenaere et al. (2015)	Comparison of what physicians and patients consider important in being cured from depression	Cross-sectional design 426 primary and secondary care patients 118 physicians	• HDRS • DEsCRIBE questionnaire	17/20 .85	Y

*Note.*CES-D = Centre for Epidemiologic Studies-Depression Scale (Radloff, 1977); HDRS = Hamilton Depression Rating Scale (Hamilton, 1967); HRSD = Hamilton Rating Scale-Depression (Hamilton, 1986); MD = major depression; SCID-II = Structured Clinical Interview for DSM-III-R Personality Disorders (Spitzer, Williams, Gibbon, & First, 1989).

Results

Overview

Table 2 summarises the key findings from reviewed studies. Results are presented in accordance with the review's aims, following three main themes: (i) recovery and gender; (ii) social support; and (iii) patient and clinician perspectives.

Critique of Papers

As indicated in Table 1, the papers included in the review were all assessed as having at least moderate quality. However, quality ratings varied from .75 (Fullagar& O'Brien, 2014; Johnson, Gunn, &Kokanovic, 2009) to .95 (Vidler, 2005). Stronger papers were characterised by robust study designs, inclusion of detailed participant characteristics, use of well-defined outcome measures, appropriate sample sizes, and drew conclusions that were supported by results. Stronger qualitative papers used verification procedures to establish credibility, and contained researchers' reflections on the impact that their own personalcharacteristics might have had on the data obtained. Weaker papers lacked verification procedures and reflexivity (qualitative papers), and had less robust study designs.

One limitation of the QualSyst tool is that the checklists consist of items that the researchers perceive to represent research quality, defined in terms of internal study validity (Kmet, et al., 2004). As such, the checklists do not assess the psychometric properties of measures used in studies. The studies included in this review contained a range of depression measures and/or researcher-developed interview schedules. The quality and validity of these measures has therefore not been considered when assessing studies' research quality.

Table 2.

Overview of findings from reviewed studies (N = 14)

Author(s) and year	Examined perceptions of:	Key findings
George, Blazer, Hughes, & Fowler (1989)	Secondary care patients	• Size of social network and subjective social support were significant predictors of depressive symptoms at follow-up, with perceptions of inadequate social support generally predicting higher levels of depression. • Subjective social support was strongly associated with major depression, with a significantly stronger effect for middle-aged than older adults, and for men more than women.
Brugha, Bebbington, MacCarthy, Wykes, & Potter (1990)	Outpatients	• Higher levels of social support predict clinical improvement and recovery from depression. • Perceptions of social support differed between men and women, indicating that associations between personal relationships and recovery varied with gender.
Schreiber (1996)	Community sample	• The basic social psychological process of women's recovery from depression could be summarised as (re)defining the self. • (Re)defining the self considers the individual women and the social context in which their lives are situated, as opposed to more traditional conceptualisations of recovery that focus on symptoms.
Brown, Schulberg, &Prigerson (2000)	Primary care patients	• Lower depression symptom severity at eight months was associated with higher baseline functioning, minimal medical comorbidity, race and standardised treatment (interpersonal psychotherapy or nortriptyline). • Greater symptom reduction was experienced by individuals who both perceived more self-control over their health and received standardised treatment. • Individuals who received a standardised treatment perceived greater levels of control over their health, and were more likely to recover at eight months, than those who received usual care. They also lacked lifetime generalised anxiety or panic disorder.

Table 2 - *continued*

Author(s) and year	Examined perceptions of:	Key findings
Badger & Nolan (2005)	Primary care patients	• Recovery from depression was perceived as having multiple causes, including medication, passage of time, and personal strengths. • Practitioners who recognised and acknowledged patients' roles in recovery and supported 'portfolios' of care were perceived as caring and offering individualised care that was holistic. • Patients indicated a preference for components of care that changed as recovery progresses.
Emslie, Ridge, Ziebland, & Hunt (2005)	Community sample	• As part of recovery from depression, men reconstructed a valued sense of themselves and their own masculinity, by incorporating values into narratives. • A minority of men emphasised creativity, sensitivity, and intelligence, to redefine their 'difference' (i.e. depression) as a positive feature.
Vidler (2005)	Community sample	• Relationships and social context were central to women's experience of depression. • Recovery from depression was associated with increased self-caring and self-agency, and more active involvement in treatment decisions.
Gladstone, Parker, Malhi, & Wilhelm (2007)	Outpatients	• Perceptions of low social support were associated with objective markers of lifetime depression. • The role of interpersonal factors in maintaining depression indicates that psychotherapeutic interventions that target how to maintain or build supportive relationships, and how to cope with interpersonal stressors, might facilitate recovery.
Johnson, Gunn, &Kokanovic (2009)	Primary care patients	• Patients' assessment of recovery from depression draws on observation and human interaction, leading to indicators of recovery that include traditional symptom-based definitions of recovery. • The range of ways patients with depression describe recovery indicates a need for more patient-centred approaches to setting goals for recovery from depression in primary care settings.
O'Brien (2012)	Community sample	• The 'recovery imperative' itself may be implicated in perpetuating cycles of recovery and relapse, by adding an additional burden to women's expectations of themselves.

Author(s) and year	Examined perceptions of:	Key findings
Cruwys, et al. (2013)	Community sample	• The number of social groups that a person belongs to is a strong predictor of subsequent depression. • The benefits of social group membership are stronger among individuals who are depressed than those who are non-depressed. • Social group membership is protective against developing depression, and associated with recovery.
Fullagar& O'Brien (2014)	Community sample	• The process of recovery from depression was perceived as changing relations to the self. • Recovery constituted a generative process of caring for the self, and involved development of self-knowledge that valued 'being and doing' and capabilities. • Recovery discourses that focus on capability, rather than deficit, could contribute to more effective recovery oriented policies.
van Grieken, et al. (2014)	Community sample	• Treatment factors identified as impeding recovery from depression yielded four main themes: 1) lack of clarity and consensus about the nature of depression and the content of treatment; 2) precarious relationship with clinicians; 3) unavailability of mental health care; and 4) insufficient involvement of significant others.
Demyttenaere, et al. (2015)	Primary & secondary care patients Physicians	• Physicians' views of what is important in being cured from depression differ significantly from patients'. • Whilst physicians' focus is on alleviation of depressive symptoms, patients' focus is on restoration of positive affect.

Recovery and Gender

Five papers used qualitative research methods to investigate the perceptions of recovery held by men and women. An overall total of 121 participants, 13.2% male and 86.8% female, participated in the included studies. Participants' ages ranged from 22 to 75 years. Only one study (Vidler, 2005) used measures in addition to researcher-developed semi-structured interview schedules.

Departure from normalised, symptom-focused perceptions of recovery was a theme across all five studies. Schreiber (1996) presented a model of recovery, (re)defining the self, which considers the individual women and the social contexts in which they are situated. Recovery from depression – or (re)defining the self - is defined as a social psychological process consisting of six phases: 1) my self before encountering depression; 2) seeing the abyss (confronting depression); 3) telling my story and 4) seeking understanding (two parallel processes); 5) cluing in (to facilitate understanding of the self and the world); and 6) seeing with clarity (accepting the depression journey, acknowledging vulnerabilities and developing compassion). Schreiber emphasises that recovery is a personal journey, and that the final phase can take women years to reach.

In contrast to Schreiber's model, O'Brien (2012) found women's efforts to understand themselves and the world both impeded recovery and contributed to their depression. Furthermore, whilst Schreiber's model implies a linear recovery trajectory, O'Brien argues that attempts to follow linear, normalised recovery pathways leave women unable to maintain the trajectory that will lead to recovery, whilst relapses back into depression create a perpetual struggle to move towards normative concepts of recovery. O'Brien's research identified a

sense of responsibility amongst women to undertake work to ‘fix’ their depression, and an expectation that recovery meant a return to previous normal functioning. Women’s inability to return to previous normal functioning was interpreted as failure to recover, compounded by societal gender expectations. O’Brien concludes that the recovery imperative places an additional burden on women’s expectations of themselves, whilst social constructions of gender both create women’s depression and impede their recovery.

Associations between societal gender expectations and recovery from depression were also identified by Vidler (2005). Women’s experiences of depression were found to be associated with continual interactions between the ‘self’ and ‘other/s’. When these interactions occurred within the context of societal gender expectations that women would engage in self-sacrificing and self-silencing behaviours, depression developed. Recovery from depression was facilitated by women rebalancing their focus of care away from others and onto themselves, by attending to their own needs as opposed to the needs of others. Vidler also found that all but one of the women who had recovered from depression were also no longer in intimate relationships, increasing their self-agency and ability to engage in self-care practices.

Fullagar and O’Brien (2014) also found that societal gender expectations were associated with ‘normalised recovery’, whereby recovery from depression would return women to “productive roles at home and work” (p.119). Women’s perceptions of recovery were found to contrast with societal perceptions of recovery as a straightforward process, whereby symptoms are reduced through medication and ‘normal’ functioning resumes. Consistent with Vidler’s (2005) findings, Fullagar and O’Brien also identified associations between women’s ability to engage in self-care practices and recovery from depression,

emphasising the role of self-agency and ability to take control of one's life. Recovery was also found to be a "complex process that involved translating emotions, multiple meanings and gender expectations about oneself as a woman at mid-life" (p.121). By redefining recovery beyond normalised, biomedical definitions, women were able to develop knowledge about themselves and identify self-care activities that helped shift their self-perception from 'deficient' to caring for oneself and meeting one's own emotional needs. As such, Fullagar and O'Brien argue that perceptions of recovery should shift from deficit models to viewing recovery as a social practice, whereby women realise opportunities to embody different 'beings and doings' through self-care.

Only one study explored men's perspectives of recovery from depression (Emslie, Ridge, Ziebland, & Hunt, 2005). Consistent with the studies described above, construction of self was identified as central to recovery. However, men placed importance on reconstructing a valued sense of themselves and their own masculinity that embraced socially constructed gender identities. Men's recovery from depression was facilitated through incorporation of values associated with hegemonic masculinity (those emphasising control, strength and responsibility to others) into rich narratives. However, the pressures of conforming to gender expectations were associated with suicidal behaviour in a minority, who perceived suicide as either courageous or the ultimate means of establishing control, consistent with gender expectations.

In summary, men and womenperceive recovery from depression as a complex, personal journey. Neither gender supported the concept of normalised, biomedical definitions of recovery,and acknowledged associations between attempting to meet normative concepts of recovery and relapsing into depression. Furthermore, both genders identified construction of self and

societal gender expectations as central featuresof recovery. However, gender differences emerged in relation to the impact of social constructions of gender on recovery. Women described societal gender expectations as contributing towards depression and hindering recovery, limiting their self-agency and ability to self-care. In contrast, men embraced socially constructed gender identities and reported that incorporating values associated with hegemonic masculinity into their life narratives facilitated recovery.

Social Support

Four studies used quantitative research methods to investigate the role of social support in recovery from depression.An overall total of 5553 participants, 44.8% male and 55.2% female, participated in the included studies. Participants' ages ranged from 16 to 90 years. All of the studies used combinations of clinical interviews, researcher-developed questionnaires, or psychometric measures to assess a range of variables.

George, Blazer, Hughes, and Fowler (1989) investigated associations between social support and the outcome of major depression. They found that size of social network and subjective social support were the most significant predictors of depressive symptoms at follow-up, with the exception of depression scores at baseline. Perceptions of inadequate social support generally predicted higher levels of depression. Impaired subjective social support was strongly associated with major depression, with stronger effects found for men more than women, and middle-aged adults more than older adults. However, this study's strict inclusion criteria and recruitment of participants from a single inpatient facility limit the generalisability of findings. Furthermore, recovery from depression and social support were measured through self-report measures alone at follow-up, carrying potential for response

bias. It is also possible that participants' perceptions of social support were negatively affected by their depression symptoms, leading to falsely deflated ratings.

Addressing these limitations, Brugha, Bebbington, MacCarthy, Wykes, and Potter (1990) investigated associations between initial levels of social support and recovery from depression. Participants were recruited following outpatient clinic attendances and completed a series of clinical interviews to measure both depression and social support. Higher numbers of close relationships, increased contact with members of social support networks, and increased satisfaction with support received, predicted clinical improvement and recovery from depression in women. In men, negative social interaction, living as married, and number of social contacts named as acquaintances or friends, predicted clinical improvement and recovery from depression. The differing perceptions of social support indicate that associations between personal relationships and recovery varied with gender.

Gladstone, Parker, Malhi, and Wilhelm (2007) also investigated perceptions of social support held by clinically depressed patients. They found that perceptions of low social support were associated with objective markers of lifetime depression, particularly when family members were perceived as providing low social support. Lower perceived social support was also associated with greater depression symptomatology. Subjective reports further indicated that 51.2% of participants felt that lack of perceived social support posed complications for recovery from depression. Gladstone,et al. suggest that recovery from depression might be facilitated by psychotherapeutic interventions that target development and maintenance of supportive relationships, and how to cope with interpersonal stressors. However, it must be

noted that although this study demonstrates associations between perceived social support, depression symptomatology, and recovery from depression, it does not establish a causal relationship. It therefore remains unclear whether perceptions of social support are clouded by depression symptoms, or whether depression symptoms trigger erosion of social support networks over time.

To address the question of causation, Cruwys, et al. (2013) investigated the role of social group memberships in alleviating depression symptoms, protecting against future depression and preventing depression relapse. They found that the number of social groups a person belongs to is a strong predictor of subsequent depression, with membership of fewer groups predicting greater levels of depression. The benefits of social group membership were found to be stronger amongst individuals who are depressed than those who are non-depressed, after controlling for confounding variables. Furthermore, proximal and distal analyses indicated that risk of depression relapse decreased by 24% in participants with depression who joined one social group (from zero), and by 63% if they joined three groups. Cruwys, et al. conclude that social group membership is both protective against developing depression, and facilitates recovery from depression by providing a ‘social cure’ for people already experiencing depression. However, generalisability of the study’s findings is limited by a sample that is predominantly white and aged over 50.

To summarise, higher levels of perceived social support and group memberships are shown to be associated with lower depression symptomatology and recovery from depression. Limited evidence indicates gender differences in perceptions of social support, although these have not been confirmed.

Patient and Clinician Perspectives

Five studies investigated patients' perspectives about what is important in recovering from depression, with one also investigating clinicians' perspectives (Demyttenaere, et al., 2015). Of these five studies, two used quantitative research methods (Brown, Schulberg, &Prigerson, 2000; Demyttenaere, et al., 2015), and three used qualitative methodology (Badger & Nolan, 2005; Johnson, Gunn, &Kokanovic, 2009; van Grieken, et al., 2014). An overall total of 1270 participants, 29.4% male and 70.6% female, participated in the included studies. Participants' ages ranged from 18 to 75 years. All of the studies used combinations of clinical interviews, researcher-developed interview schedules, or psychometric measures to assess a range of variables.

Brown, et al. (2000) investigated factors associated with symptomatic improvement and recovery from major depression in primary care patients. Lower depression symptom severity at eight months follow-up was associated with higher baseline functioning, minimal medical comorbidity, having an ethnicity reported as white, and receiving a standardised treatment (interpersonal psychotherapy or nortriptyline). Greater symptom reduction was experienced by individuals who both perceived more self-control over their health and received standardised treatment. Furthermore, individuals who received a standardised treatment perceived greater levels of control over their health, and were more likely to recover from depression than those who received usual care. They also lacked lifetime generalised anxiety, panic, or personality disorder. In addition, analyses demonstrated that individuals in part- or full-time employment and with lower functional impairment at baseline were more likely to meet recovery criteria at follow-up. These results indicate that recovery from depression is influenced by factors such as health beliefs, non-

depressive psychopathology, and higher levels of functioning, as well as clinical severity at baseline and adequacy of any treatments provided. However, the generalisability of the study's findings may be limited by the predominantly female sample.

Two studies examined accounts of recovery and perceptions of treatment amongst primary care patients (Badger & Nolan, 2005; van Grieken et al., 2014). Badger and Nolan found that recovery from depression was perceived as having multiple causes, including:social support, particularly from family members; medication and psychoeducation;responsive and caring practitioners; passage of time and timely interventions; and personal strength. As such, patients acknowledged the multi-factorial nature of recovery from depression, and accordingly expressed a preference for individualised components of care that change as recovery progresses. However, the authors' acknowledgement that the primary care practices involved in the study had an interest in mental health might suggest that results are not wholly generalisable to other practices and populations.

Consistent with findings from Badger and Nolan's (2005) study, patients interviewed by van Grieken, et al. (2014)identified a range of treatment factors that were perceived to impede their recovery from depression, based around four main themes: 1) lack of clarity and consensus about the nature of depression and the content of treatment; 2) precarious relationship with clinicians; 3) unavailability of mental health care; and 4) insufficient involvement of significant others, preventing full use of support networks. These themes are consistent with those identified by Badger and Nolan, particularly the benefits of information about treatment options, responsive and caring practitioners, and appropriate use of social support networks. As with Badger and Nolan's study,

the generalisability of findings from van Grieken's research to other populations is hampered by participants' limited socio-demographic backgrounds.

Consistent with Badger and Nolan's (2005) findings, Johnson, Gunn, and Kokanovic (2009) found that the range of ways primary care patients with depression describe recovery indicates a need for more patient-centred approaches to setting goals for recovery from depression. Patients described assessing a person's recovery from depression on the basis of observation and human interaction, specifically their actions and interactions with others, their appearance, and their thoughts and feelings. However, some participants identified difficulty in assessing recovery amongst people who successfully hide their depression. Johnson, et al. suggest that the indicators of recovery identified by participants contrast with more traditional symptom-based definitions of recovery.

Demyttenaere et al. (2015) compared physicians' and patients' perspectives of what is important in being 'cured' from depression. They found that perspectives differed significantly, with physicians focusing on alleviation of depression symptoms, and improvements in functioning and quality of life, and patients focusing on restoration of positive affect (for example, having a meaningful and enjoyable life, ability to concentrate, personal strength, and satisfaction with personal relationships). Both physicians and patients consistently rated somatic symptoms as least important in being 'cured' from depression. Patients experiencing recurrent depression placed greater focus on restoration of positive affect than those patients experiencing a first episode of depression, and all patients placed greater focus on restoration of positive affect at three months follow-up. Demyttenaere et al. conclude that physicians and patients place importance on different factors when considering recovery from

depression, carrying implications in terms of defining recovery from depression, and use of symptom-based depression measures. However, as this is the only study to investigate clinicians' perspectives of patient recovery from depression, replication is essential.

To summarise, recovery from depression is influenced by a range of factors. These include health beliefs, non-depressive psychopathology, and higher levels of functioning, clinical severity at baseline, and treatment adequacy. The role played by support systems in facilitating recovery, including responsive and caring practitioners, was also emphasised. Patients described assessing a person's recovery from depression on the basis of observation and human interaction, and prioritise restoration of positive affect in recovery from depression. However, physicians' and patients' perspectives differ significantly in terms of what is important in being 'cured' from depression.

Discussion

This review aimed to synthesise the existing literature investigating perceptions of, and factors associated with, recovery from depression in adults. Results from the studies included in this review followed three main themes: (i) recovery and gender; (ii) social support; and (iii) patient and clinician perspectives.

Summary of Findings

Throughout the literature, recovery from depression was perceived as a complex, personal journey. Normalised, biomedical, symptom-based definitions of recovery were not supported by patients of either gender (Emslie, et al., 2005; O'Brien, 2012; Schreiber, 1996), with associations made between attempts to meet normative concepts of recovery and relapses into depression (Fullagar& O'Brien, 2014; O'Brien, 2012). Construction of the self, including

self-care and self-agency, and management of societal gender expectations were identified as central features of recovery (Vidler, 2005).

Whilst Schreiber (1996) found that women's efforts to understand themselves and the world facilitated recovery from depression, O'Brien (2012) found that such efforts both impeded women's recovery and contributed to their depression. In particular, O'Brien found that women interpreted inability to return to previous normal functioning as failure to recover, compounded by societal gender expectations. The discrepancy between the two studies is potentially attributable to age differences between the women interviewed, with O'Brien focusing on women in mid-life (aged 35-49 years) and Schreiber focusing on women aged 32-69 years. It is possible that reports by women in O'Brien's study relating to the effects of societal gender expectations were concentrated to a greater extent than those in Schreiber's study, due to expectations relating to employment, motherhood, and marriage.

Recovery from depression was found to be associated with higher levels of perceived social support, and increased group memberships (Brugha, et al., 1990; Gladstone, et al., 2007; George, et al., 1989). Social group membership was also found to be protective against developing depression, and to facilitate recovery (Cruwys, et al., 2013). Furthermore,responsive and caring practitioners were identified as contributing towards effective support systems and facilitating recovery (Badger & Nolan, 2005; van Grieken, et al., 2014).

Recovery was further associated with a range of factors including health beliefs, non-depressive psychopathology, higher levels of baseline functioning, clinical severity at baseline, medication, and treatment adequacy (Badger & Nolan, 2005; Brown, et al., 2000; van Grieken et al., 2014). Whilst patients prioritise restoration of positive affect in recovery from depression, physicians

were found to prioritise alleviation of symptoms, and improvements in functioning and quality of life (Demyttenaere, et al., 2015). Furthermore, patients describe assessing recovery from depression on the basis of observation and human interaction, as opposed to more traditional symptom-based definitions of recovery (Johnson, et al., 2009).

Methodological Critique

Methodological weaknesses across the studies included in this review, including issues of generalisability and limited replication of findings, limit the strength of the conclusions drawn. The predominance of qualitative research methodology across the studies further limits both comparisons across studies and wider generalisation of findings, as focus is on participants' subjective experiences as opposed to objective measurement. Furthermore, the qualitative data analysis methods varied across the studies, again hindering direct comparison. Nevertheless, overarching themes did emerge across the existing literature (for example, recovery as a complex, multi-faceted process; the influence of social support networks; and lack of support for normalised, symptom-based concepts of recovery), increasing the credibility of findings.

Across the studies included in this review, there was wide variation in sample sizes, ranging from 16 (Emslie, et al., 2005) to 5055 (Cruwys et al., 2013). Whilst this in part reflects the diverse research methodology, the demographic of participants was characterised by a majority female sample (58.6%), lack of ethnic diversity, and recruitment solely within developed countries. It could be argued that the greater prevalence of depression amongst women than men across all age groups (Angst, et al., 2002) warrants a greater proportion of female participants in recovery research. Nevertheless, the

generalisability of findings beyond the demographic of participants included in the existing literature is limited.

A predominance of researcher-developed measures, particularly within the qualitative studies, further limits the ability to make cross-study comparisons. This predominance reflects the complexity of assessing and measuring perceptions of recovery. Furthermore, studies that employed standardised measures of depression used a range of measures, the quality of which was not assessed as part of this review. The range of measures used (both researcher-developed and standardised) potentially limits the ability to make comparisons between studies as assessment of depression severity or recovery is likely to vary.

Finally, the quality scores of included studies varied, such that findings from higher quality studies might outweigh findings from lower quality studies. However, differences in quality rating scores reflect the diversity of study designs and methodologies used. Furthermore, as mentioned above, all of the studies included in the review were assessed as having moderate to high quality.

Implications for Clinical Practice

Despite the methodological weaknesses described above, the results of this review carry a range of implications for clinical practice. A key finding that clinicians working with adults experiencing depression should be aware of isthat recovery from depression is a complex process, consisting of multiple facets (Badger & Nolan, 2005; Brown, et al., 2000; Schreiber, 1996). Whilst clinicians tended to define recovery from depression in terms of alleviation of symptoms, and improvements in functioning and quality of life, patients focused more on restoration of positive affect (Demyttenaere et al., 2015). As such, clinicians

should be aware that symptom-based definitions of recovery based on routine depression measures do not necessarily indicate recovery according to patient perspectives.

Clinicians should be aware of the potential impact of societal gender expectations in maintaining or exacerbating patients' depression, and of the positive associations between increased self-care, self-agency and recovery (Fullagar& O'Brien, 2014; Vidler, 2005). This is particularly the case in relation to patient-practitioner relationships, with patients identifying practitioners who acknowledge patients' own roles in managing their depression and support individualised care as influential in assisting the recovery process (Badger & Nolan, 2005; van Grieken, et al., 2014). As such, clinicians should consider routine use of patient-centred approaches to setting goals for recovery from depression (Johnson, et al., 2009), and monitor the alliance between themselves and their patients to enable proactive identification and repair of potential ruptures.

The positive impact of social support and benefits of group membership in terms of protecting against, and assisting recovery from, depression should also be noted (Cruwys, et al., 2013). Clinicians should therefore implement routine screening of patients' access to social groups, with a view to facilitating group membership amongst clients identified as having little or no access. Furthermore, clinicians should consider specific use of psychotherapeutic interventions to reduce the potential impact of depression on patients' perceptions of social support, facilitate social inclusion, and improve patients' ability to negotiate interpersonal challenges, such as cognitive-behavioural therapy (Beck, 1979) or interpersonal psychotherapy (Klerman, Weissman, Rounsaville, & Chevron, 1984).

Future Research

The findings from this review emphasise that recovery is a complex process, influenced by a range of factors. However, the findings themselves highlight specific gaps and methodological weaknesses within the existing literature. As such, a range of recommendations for future research can be made that would increase the credibility of the existing evidence base.

First, the existing literature uses a range of measures to assess depression and recovery, hindering cross-study comparisons. Future researchers should endeavour to consider the psychometric properties of measures used. Consideration should also be given to the content of measures used, due to the predominance of somatic, symptom-based items and research indicating that these factors are not considered important by either physicians or patients in assessing recovery from depression (Demyttenaere et al., 2015). When considering the validity of measures, future researchers should also consider the validity of the construct of 'recovery'. Whilst it is possible that patient-centred definitions of recovery from depression (incorporating quality of life, absence of suicidality, social support, and employment factors) are more pertinent when considering long-term relapse prevention strategies, compared with clinician-centred definitions (incorporating alleviation of depression symptoms, improvements in functioning, and quality-adjusted life years), the existing literature outlined above does not allow for any conclusions to be made as to this hypothesis.

Second, tentative gender differences emerged in perceptions of recovery from depression and the impact of societal gender expectations (Emslie, et al., 2005; Fullagar& O'Brien, 2014; O'Brien, 2012; Vidler, 2005). However, only one study conducted in-depth analysis of men's perceptions of recovery from

depression (Emslie, et al., 2005). As such, future research should aim to directly compare perceptions of recovery held by men and women to improve the credibility of the existing evidence base. As tentative gender differences also emerged regarding perceptions of social support (Brugha, et al., 1990; George, et al., 1989), replication of these findings would also be beneficial due to the potential for tailoring therapeutic interventions that target these perceptions.

Third, associations identified between client-practitioner relationships and recovery from depression warrant further investigation. In particular, replication of findings that recovery is facilitated by responsive and caring practitioners who recognise a role for individualised components of care (Badger & Nolan, 2005; van Grieken, et al., 2014) could inform how care is delivered to this client group, with implications for enhancing recovery rates.

Finally, differences emerged between physicians' and patients' perceptions of what is important in being in recovery from depression (Demyttenaere et al., 2015). However, as it is not possible to conclude whether these differences were influenced by methodological factors (quantitative research methodology as opposed to qualitative methodology), replication of these findings is essential. Future research would benefit from in-depth comparison of physician and patient attitudes towards recovery from depression, to confirm the divergence of opinion and to inform clinical practice. Use of a mixed methods approach in future studies would enable confirmation of differences in perceptions through quantitative measures, complemented by in-depth qualitative analysis of both patients' and practitioners' perceptions of recovery from depression.

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Note. Asterisk indicates papers included in the review.

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Appendices

Appendix 1.QualSyst quality appraisal checklist for quantitative studies

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Appendix 2.QualSyst quality appraisal checklist for qualitative studies

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Section Two: Research Report

Investigating therapists' perceptions of recovery, and associated factors, inImproving Access to Psychological Therapies services: A mixed methods study

Abstract

Objective: Recent research has identified significant differences between clinicians' and patients' perspectivesof what is important in being in recovery from depression. The present study sought to further investigate clinicians' perceptions of patient recovery from mental health difficulties.

Design: This study used a mixed-methods exploratory design.

Method: Semi-structured interviews were conducted with 17 participants, who also completed measures of resilience and empathy. Interview transcripts were analysed using template analysis. Chi-squared tests of independence were used to investigate whether therapists' personal qualities were related to emergent themes.

Results: Analysis of participants' transcripts yielded five superordinate themes relating to: therapist-specific and client-specific initial session 'wants'; therapists' definitions of 'recovery'; the meaning of 'recovery' to patients; personal qualities in therapists and clients beneficial for promoting recovery; and barriers to recovery.

Conclusions: Participants perceived clients' recovery as a complex, personal process influenced by a range of factors. Significantly more therapists classed as having high cognitive empathy identified complexities in defining recovery. 'Recovery' was defined using objective changes witnessed during therapy, self-reported changes, and changes in patients' scores on outcome measures.Participants consistently identified a range of tensions and complexities relating to use of service definitions of recovery (based on cut-off scores on outcome measures), citing a preference for clinically-based definitions that draw on information and observations that arise during the therapeutic process.

Practitioner Points

- Identification of the processes used by therapists to assess recovery carries implications for supervision and training. In addition to monitoring changes in clients' scores on outcome measures, emphasis should be placed on developing therapists' skills in combining objective changes witnessed during therapy with self-reported changes to assess recovery.
- Practitioners in supervisory roles should explore the personal and professional impact of referring to recovery rates on individual therapists. Particular consideration should be given to ensuring that decisions around starting and ending episodes of care are clinically sound and not unduly influenced by therapists' recovery rates.
- Practitioners in supervisory roles should explore therapists' and clients' 'wants' and expectations of therapy to ensure that identified therapy goals are representative of both what patients want and what is clinically indicated, such that recovery is personalised.
- Consideration should be given to the wider use of reliable and clinically significant change in scores on outcome measures to define recovery within IAPT.
- Future research should seek to establish the applicability of the results described to other psychological services.

Introduction

Across the UKannually, an estimated 16.2% of adults aged 16-64 will meet the diagnostic criteria for an anxiety- or depression-based mental health condition (McManus et al., 2009). The National Institute for Health and Clinical Excellence (NICE) has termed these conditions ‘common mental health disorders’ (NICE, 2011), and published a series of clinical guidelines to aid their identification and treatment, including the use of psychological therapies.

In response to findings that people experiencing depression or anxiety disorders had difficulty accessing psychological therapies (Layard, 2005), the Improving Access to Psychological Therapies (IAPT) programme was introduced nationally in 2008. Designed to improve access to evidence-based psychological therapies for people experiencing depression and anxiety disorders, a central feature of IAPT services is the availability and delivery of treatments consistent with NICE guidelines for depression and anxiety (Clark, 2011), which recommend provision of stepped-care service delivery models that provide increasingly intense psychological treatments (Bower &Gilbody, 2005).

A key characteristic of IAPT services is the use of routine outcomes measurement to monitor service quality and patient outcome. Client recovery is measured by counting all patients who score below clinical cut-off on the Patient Health Questionnaire (PHQ-9: Kroenke, Spitzer & Williams, 2001) and the Generalised Anxiety Disorder assessment (GAD-7: Spitzer, Kroenke, Williams &Löwe, 2006) by the end of treatment. As well as identifying clients who can be considered ‘recovered’, and measuring the degree of their improvement (Clark & Oates, 2014), data relating to clients who are moving towards recovery can also be used to provide an indication of therapists’ effectiveness.

Defining and Measuring Recovery

The concept of recovery within mental health is contested, with multiple definitions of the term “recovery” (Bonney &Stickley, 2008). Whilst the recovery model itself emphasises concepts such as hope, meaning and sense of self (Dickens, 2009), 16 core elements of recovery have been identified (Onken, Craig, Ridgway, Ralph,& Cook, 2007). Onken et al. incorporated the 16 elements of recovery into an ecological framework that emphasises re-establishment of mental health and mitigation of the barriers imposed by the wider community to facilitate social integration and inclusion. The emphasis on social inclusion, identity and hope within the recovery literature carries implications for the routine use of outcome measures to assess patient recovery, which do not currently incorporate these factors (Andresen, Caputi,&Oades, 2010).

Bonney and Stickley (2008) reviewed over 170 recovery papers and found consensus around the belief that service users should receive good quality care to promote recovery. However, there is a clear tension between national approaches to service delivery and calls for individually tailored care that promote recovery. Indeed, Slade (2012) distinguishes between clinical recovery and personal recovery. He proposes that clinical recovery focuses on professional imperatives, as opposed to service user views, whilst personal recovery is more ideological, focusing on connectedness; hope and optimism; identity; meaning and purpose; and empowerment. Drawing on these principles, the Implementing Recovery through Organisational Change programme has identified quality indicators for supporting recovery at individual and organisational levels, alongside recommendations for recovery outcomes measures (Shepherd, Boardman, Rinaldi, & Roberts, 2014).

Within IAPT, ‘recovery’ is specifically defined, drawing primarily on clinical cut-off scores on the PHQ-9, GAD-7, and anxiety disorder-specific measures. As such, Williams (2015) recommends that: “clinicians need to be sure that the measures supporting the IAPT programme measure the reality of a depressed state or an anxiety state, as the outcome measures have such an influence on the programme” (p. 347).

Therapist Effects and Client Recovery

The influence of therapist effects on client recovery and patient outcome is contested within the literature. As investigation of therapist effectiveness has been limited by methodological difficulties (Hubble, Duncan, & Miller, 1999), research has either focused on patient outcomes and the presence of therapist effects, or individual characteristics of the therapists themselves (Jennings &Skovholt, 1999; Najavitis,&Strupp, 1994).

Two recent studies have used mixed methods designs to simultaneously investigate therapist effects and practitioner features. Green, Barkham, Kellett, and Saxon (2014) found that more effective(as measured by patient outcome) Psychological Wellbeing Practitioners (PWPs) displayed greater resilience, organisational abilities, knowledge and confidence than less effective PWPs. Pereira (2014) found that more effective therapists had higher levels of mindfulness and resilience, and lower levels of empathy. Higher levels of therapist resilience werealso associated with more positive outcomes for patients presenting with moderate difficulties. A particular strength of both studies is the use of mixed methods to yoke therapist characteristics (resilience and empathy) and effects to qualitative results, which is unusual within therapist effects research (Green et al., 2014).

Importance of Examining Therapists' Perspectives

The majority of research into perceptions of recovery to date has focused on patients' experiences of recovering from psychosis or schizophrenia (Bonney &Stickley, 2008), or the personal qualities beneficial for recovery (Onken et al., 2007). There has been relatively little investigation of therapists' perceptions of recovery, particularly in relation to recovery from the most frequent mental health conditions seen within IAPT services, such as anxiety and depression (Health and Social Care Information Centre, 2014).

A recent literature review (Richardson, 2016) has summarised the existing literature investigating patients' and clinicians' perceptions of, and factors associated with, recovery from depression. The review found that recovery from depression is perceived by patients as a complex, personal process that is influenced by a range of factors. Only one study was identified that investigated clinicians' and patients' perspectives of recovery (Demyttenaere, et al., 2015). This study found that clinicians and patients differed significantly in terms of what is important in being in recovery from depression. As such, greater understanding of both clinicians' and patients' perceptions of patient recovery from depression is essential to inform clinical practice and influence future research.

The present study seeks to address the need to get a detailed understanding of clinicians' accounts of recovery by employing qualitative research methods to investigate the perceptions of patient recovery held by therapists working into IAPT services. Drawing on recent research findings by Green et al. (2014) and Pereira (2014), which identified associations between therapists' characteristics (resilience and empathy) and patient outcomes, the

present study also measured therapists' resilience and empathy to investigate whether therapists' personal qualities were related to emergent themes.

As this research aimed to compare the perspectives of different groups of staff within IAPT (Cognitive-Behavioural Therapy [CBT] therapists, counsellors, and PWPs)the thematic organisation and analysis of qualitative data employed template analysis techniques (King, 2004). Template analysis has also been identified for use within a critical realist position (Madill, Jordan, & Shirley, 2000), which assumes an "inherent subjectivity in the production of knowledge" (p. 3), and depends on the researcher's position and specific context of the research. When following a critical realist position, King (2004) emphasises the importance of researcher reflexivity, consideration of the researcher-participant relationship, and the need to explicitly ground interpretations and analytical decisions in the data.

The current study therefore aimed to investigatetherapists' perceptions of client recovery from mental health difficulties, and associated factors. The study also aimed to tentatively investigate whether these perceptions were affected by therapists' levels of empathy and resilience.

Method

Ethical Considerations

Ethical approval for the study was granted by the University of Sheffield's Department of Psychology Research Ethics Committee (see Appendix 3). Particular consideration was given to informed consent and confidentiality.

Informed consent. Informed consent to participate in the study was facilitated through a Participant Information Sheet (Appendix 4), which contained information about the study, what participation would involve, and any potential risks and benefits of participation. Before proceeding with interviews,

participants were asked to confirm that they had read the information sheet, given an opportunity to ask any further questions, and asked to provide written consent to participate in the study (see Appendix 5 for copy of consent form).

Confidentiality. To ensure confidentiality, the interview transcriber was required to complete a confidentiality agreement before recordings were submitted for transcribing. Any information that could potentially lead to identification of participants was removed from transcripts. Participants were also requested to refrain from including patient-identifiable information in their responses to interview questions.

Design

Consistent with recent research (Green et al., 2014; Pereira, 2014), the present study used a mixed-methods exploratory design to investigate therapist effects and perceptions of recovery within IAPT services. In the first phase of the study, template analysis was used to analyse data from semi-structured interviews. Template analysis was selected as the technique enables investigation of different responses to particular situations, and comparison of the perspectives of different groups within an organisational context. The study adopted a critical realist position, which acknowledges that our understanding of an independent, material reality is subject to culturally mediated acts of interpretation (Sayer, 2000).

In the second phase, results from quantitative data analyses of measures (see Data Analysis, below) completed by participants were applied to the final template to tentatively investigate whether particular themes were related to therapists' personal qualities (empathy and resilience).

Recruitment

All staff working within IAPT services located in a city in South Yorkshire received an email invitation outlining the purpose of the research (see Appendix 6). Individuals wishing to participate in the research were invited to contact the lead researcher to arrange a time to attend the interview. A further email invitation was sent six weeks after the first, providing a second opportunity for individuals to express an interest in participation.

Inclusion criteria. Participants were required to be over the age of 18, currently work within IAPT services, be willing to talk about their experience, be fluent in the English language, and have provided informed consent.

Participants

To ensure adequate representation of staff views, 17 participants were included in this research (see Table 3 for a full summary of demographic information). Fourteen participants were female. Participants' mean age was 44.0 years (SD = 14.5). Participants were distributed evenly across the three professional groups. Overall, participants had spent approximately four years in their current IAPT roles (M = 4.15; SD = 2.45), and nearly six years working for IAPT in total (M = 5.76, SD = 2.79).

Table 3.*Participant demographic data*

Variable	N (%) of participants	Range	Mean (SD)
Gender			
Female	14 (82.4)		
Male	3 (17.6)		
Age (years)		*	44.0 (14.5)
21-30	4 (23.5)		
31-40	4 (23.5)		
41-50	2 (11.8)		
51-60	5 (29.4)		
60+	2 (11.8)		
Profession			
CBT therapist	5 (29.4)		
Counsellor	6 (35.3)		
PWP	6 (35.3)		
Time in current role (years)		0-8	4.15 (2.45)
0-2	6 (35.3)		
3-5	5 (29.4)		
6-8	6 (35.3)		
Time in IAPT (years)		2-8	5.76 (2.79)
0-2	3 (17.6)		
3-5	5 (29.4)		
6-8	9 (53.0)		

*Age range not provided to protect participant confidentiality.

Measures

Participants completed measures of empathy and resilience when they attended their interviews.

Basic Empathy Scale (BES:Jolliffe& Farrington, 2006). The BES (Appendix 7) is a 20-item measure of overall, affective, and cognitiveempathy. The Affective Empathy (AE) subscale measures emotional congruence with another person's emotions. The AE subscale consists of 11 items and has good internal consistency (α = .85). The Cognitive Empathy (CE) subscale measures ability to understand another's emotions. The CE subscale consists of nine items and has good internal consistency (α = .79). Participants rate items on a 5-point scale, where 1 = *strongly disagree* to 5 = *strongly agree*. Eight items are reverse scored on a 5-point scale, where 1 = *strongly agree* to 5 = *strongly disagree*. Higher scores reflect greater empathy. Jolliffe and Farrington (2006) reported normative data in an American non-clinical sample (total BES score for males: M = 64.3, SD = 9.8; total BES score for females: M = 75.3, SD = 8.3; AE

score for males: M = 32.1, SD = 6.5; AE score for females: M = 40.3, SD = 5.8; CE score for males: M = 32.2, SD = 5.1; CE score for females: M = 35.0, SD = 3.9). The BES has good construct, convergent, and divergent validity (Jolliffe& Farrington, 2006).

Connor-Davidson Resilience Scale-10 (CD-RISC-10: Campbell-Sills & Stein, 2007). The CD-RISC-10 (Appendix 8) is a self-report scale that measures an individual's perception of their resilience. It is a briefer version of the 25-item CD-RISC (Connor & Davidson, 2003) and was selected because it eases respondent burden. Correlation between the 25 and 10-item scales was *r*>.90. Items are rated on a 5-point scale, where 0 = *not true at all* and 4 = *true nearly all the time*. Higher scores reflect greater resilience. Internal consistency of the 10-item CD-RISC is good, with α = .85 (Campbell-Sills & Stein, 2007). Campbell-Sills, Forde, and Stein (2009) reported normative data in an American non-clinical sample (M = 31.8, SD = 5.4).

Procedure

During the recruitment phase, a pilot interview was conducted with a past worker in IAPT services to ensure familiarity with the questions and interview structure. Potential ambiguities with wording identified during the pilot interview were amended, and any gaps or duplication in the questions removed.

Individuals who responded to invitations to participate were given an opportunity to ask any questions before arranging a meeting in their preferred location. Semi-structured interviews were conducted at a time and place of the participants' choosing. During this meeting, participants completed brief measures of empathy and resilience. With consent, all interviews were digitally recorded. All interviews used the same interview schedule (see Figure 2, below, for key extracts; see Appendix 9 for the full schedule), with prompts used when

necessary. Following their interview, participants were debriefed, and offered opportunities to talk about their experience and ask any further questions.

Background

1. When a patient comes to you for therapy, as a practitioner what are your 'wants' for them?

Recovery

2. Thinking about recovery, what does 'recovery' mean to you as a therapist?
   Prompts: When would you consider a client to be 'recovered'? What sort of cues do you look for in your patients to assess their progression towards recovery? Is your definition based on subjective or objective information, e.g. client self-reports, scores on outcome measures? Do these cues differ according to mild, moderate or severe presentations?
3. What do you think 'recovery' means to your patients?
   Prompts: Thinking about the last five patients you've worked with, what do you think would be their benchmark for assessing whether they were recovered? What would you consider to be the most important elements of recovery for your patients?
4. What personal qualities do you think are beneficial for promoting recovery? These can relate to clients and/or therapists.

Ending questions

5. Is there anything that you would like to ask, or anything that occurred to you during this interview that you think would be important to know?

Figure 2. Interview schedule

Recorded interviews were transcribed verbatim by a third party. Individual transcriptions were made available to participants to confirm they were a true representation of the interview. Any discrepancies identified during this process were discussed with individual participants and transcripts amended accordingly following discussion.

Data Analysis

Qualitative data analysis. Consistent with research in health settings (Appleton, Fowler, & Brown, 2014; Sheen, Spiby, & Slade, 2016), template analysis techniques were used to thematically organise and analyse transcribed data using strategies described by King (2004):

***Stage 1: Definition of a priori themes*.** The interview schedule, based on items contained in the PHQ-9 and GAD-7, was used to define *a priori* themes. Four *a priori* higher-order codes were defined on the basis of the interview schedule (initial session 'wants'; defining 'recovery'; meaning of

‘recovery’ to patients; and personal qualities beneficial for promoting recovery). Themes arising from the academic literature, the researcher’s own personal experience, and anecdotal evidence were considered as potential lower-order codes (for example, empathy; resilience; symptom reduction; functioning). A conceptual map of *a priori* themes is contained in Appendix 10.

***Stage 2: Listening, reading and re-reading*.** All interviews were recorded and transcribed verbatim. Audio recordings of interviews were listened to whilst reading the interview transcripts at least twice, to ensure familiarity with both the content and the participant, and to enable the researcher to begin to engage with the data.

***Stage 3: Initial coding*.**Words, lines or sections of data relevant to the research question were identified. Sections encompassed by any *a priori* themes were coded accordingly and ‘attached’ to the identified section. Where relevant sections were identified with no theme to ‘attach’ them to, existing themes were modified or new ones devised (see Appendix 11 for an example of transcript coding).

***Stage 4: Creation of the initial template*.** Once a sub-set of transcripts was coded, an initial template was created. Themes identified in the selected transcripts were grouped into a smaller number of higher-order codes, which describe broader themes in the data. Detailed lower-order codes were used to allow for distinctions to be made both within and between cases.

***Stage 5: Development and revision of template*.** Following creation of the initial template, a further sub-set oftranscripts were coded and the template applied and revised accordingly. This process involved the insertion, merging, or deletion of codes and categories, and revision of higher-order classifications of codes in response to data analysis. As the template was applied to each

subsequent transcript, it was revised and developed. Four substantial revisions were made to the template during analysis of transcripts (see Appendix 12 for an audit trail of the template development, and Appendix 13 for a conceptual map of the final template). Towards the end of the process, no new codes emerged and saturation was therefore assumed. The final template was reapplied to the dataset, before being reviewed and finalised to ensure that themes were appropriate.

***Stage 6: Use of final template to guide interpretation of themes and presentation of data*.** The final template was used to produce an account of therapists' perceptions of client recovery from mental health difficulties.

Quality control. To ensure good research quality, the researcher referred to the QualSyst quality appraisal checklist for qualitative studies(Kmet, Lee, & Cook, 2004) during all stages of the study. Particular consideration was given to the study's rationale, design, and context, with references made to the literature around recovery and therapist effects. Data collection and analysis processes were clearly described (see Procedure and Data Analysis sections) so that the procedures could be replicated.

Credibility of the study was enhanced through verification procedures and creation of an audit trail. Specific quality control procedures recommended by King (2004) when using template analysis include respondent feedback, independent scrutiny of analysis, creation of an audit trail, and reflexivity of the account (see Reflexivity, below). To facilitate respondent feedback, all participants were invited to review their interview transcripts and comment on whether the content accurately reflected the intended meaning of their responses. Additional information gained from participants during this process was considered during the analysis of the data. Participants were also invited to

comment on the initial template as applied to their individual transcripts. Participants' feedback was discussed directly with them, and amendments made to the template as appropriate (for example, escalating lower-order themes to higher-order, or introducing new themes).

Independent scrutiny of analysis was facilitated through a peer-review process, during which a postgraduate in social sciences applied the final template to three randomly selected transcripts. Any discrepancies that arose during this process were resolved by selecting the interpretation that was most grounded in the data. No revisions to the final template were required following this process.

To facilitate transparency and credibility (Yardley, 2000), an audit trail of the research process was created. The audit trail was complemented with use of a reflexive journal, in which the researcher documented and described their thoughts relating to the research process, data analysis, and development of the template.All steps taken during the data analysis stage were described, with commentary on the changes made at each stage and why they were made.

Reflexivity. Despite being a relatively descriptive form of qualitative analysis, template analysis techniques nevertheless acknowledge the researcher's involvement in the construction of the template and interpretation of data (King, 2004). A reflexive log was kept throughout the whole research process, to ensure that the researcher's experiences and attitudes were acknowledged but did not unduly influence the findings (Elliott et al., 1999; Shaw, 2010). Explicit consideration was given to the researcher's emotional reactions to participants, and their role in identifying codes and shaping the template. Particular attention was also given to how the analysis process was influenced by the researcher's roles as a doctoral student and trainee clinician.

Statistical analyses. Descriptive statistics were used to report participants' scores on measures of empathy and resilience. Statistical analysis of professional group differences was not possible as the number of participants in each individual professional group meant analysis would be underpowered to reach any meaningful conclusion.

Chi-squared tests of independence were used to assess associations between categorical variables (for example, 'low' empathy versus 'high' empathy). Results of analyses were used to tentatively investigate associations between therapists' personal qualities (empathy and resilience) and identified themes. For the purposes of analysis, therapists were categorised as 'low' in empathy or resilience if their individual scores fell below the mean score for the sample as a whole, and 'high' if their scores fell above the mean score for the whole sample.

Results

Qualitative Findings

Detailed analysis of participants' transcripts yielded five superordinate themes relating to: initial session 'wants'; defining 'recovery'; the meaning of 'recovery' to patients; personal qualities beneficial for promoting recovery; and barriers to recovery. Each superordinate theme yielded second and/or third level themes, as depicted in Figure 3 (below). No themes emerged that were specific to individual professional groups (see Appendix 14).

1. Initial session 'wants'
    1.1. Therapist-specific
        1.1.1.Managing expectations
        1.1.2.Alliance and rapport
    1.2. Client-specific
        1.2.1.'Feeling better'

2. Defining 'recovery'
    2.1. Complexity
    2.2. Therapy-specific cues
    2.3. Service recovery
        2.3.1.Tension
    2.4. Clinical recovery
        2.4.1.Symptom changes/improved quality of life
        2.4.2.Self-reported changes
        2.4.3.Recovery journey

3. Meaning of 'recovery' to patients
    3.1. Patient benchmark: 'feeling better'
    3.2. Importance of recovery
        3.2.1. Symptom reduction
        3.2.2. Recovery 'buzz word'

4. Personal qualities beneficial for promoting recovery
    4.1. Therapist
        4.1.1.Awareness
        4.1.2.Empathy
        4.1.3.Flexibility
    4.2. Mutual
        4.2.1.Trust/faith
        4.2.2.Willingness

5. Barriers to recovery
    5.1. Lack of active engagement

Figure 3. Final template

1. Initial session 'wants'. Participants identified a range of initial session 'wants'. A distinction emerged between therapist-specific 'wants', and client-specific 'wants', perhaps indicating an awareness on the therapists' part of potential discrepancies between their own initial session 'wants' and those of their clients.

1.1. Therapist-specific. Two main therapist-specific 'wants' emerged from the data, specifically managing expectations, and creating alliance and rapport, relating to the initial sessions with patients.

*1.1.1. Managing expectations.*Managing patients' expectations was identified as a central part of negotiating a therapeutic contract and establishing goals for recovery:

P6: "Helping someone to manage expectations is really important…someone might come in with all these expectations of what they want to get out of coming to see myself and treatment, and at the same time all in a tactful way perhaps if these expectations are just unrealistic…thenI need to have a conversation with that person about their expectations and to manage them."

Therapists also identified a need to manage expectations around the course of therapy, particularly the potential for patients to feel worse before starting to feel better:

P16: "What I am aware of [is] as we start to explore feelings and the background to feelings actually the scores [on outcome measures] can get higher before they come down, in that maybe…someone will come and say 'I'm feeling much worse than I was when I first came to you' and there's a sort of bit of a heart sink but if I've been able toexplain that can happen in session one that sometimes as we explore things, things can get worse, it's part of the rhythm of the work."

A third strand of 'managing expectations' that emerged from the data was participants' awareness of a need to manage the expectations they have of themselves as therapists, and of the work itself:

P4: "For someone who's perhaps had more severe depression I suppose I've got to be careful not to look for great leaps forward because that might not actually be possible, so I suppose I have to sort of consider my expectations as well, with this great urge I have for people to be better through seeing me I have to be careful I'm not sort of wanting them to do more than they can manage."

Again, this suggests awareness on the therapists' part of potential discrepancies between their own expectations for therapy, and those of their clients. This awareness is particularly relevant when negotiating therapy goals, and carries implications for clinical supervision to ensure that expectations are fully explored.

*1.1.2. Alliance and rapport.*In addition to managing expectations, participants identified the creation of alliance and rapport as a key 'want' for them in initial sessions:

P3: "I hope that we build a good therapeutic alliance because I know from the research that that's one of the key ingredients for being a successful therapist."

The creation of alliance and rapport was also felt by participants to play a central role in helping patients identify treatment goals and begin to work towards recovery:

P7: "Hoping that I get a good kind of therapeutic relationship with them, that I can work with them to get some good goals and…a real plan on what they're wanting to change."

1.2. Client-specific.Analysis of transcripts identified one main initial session 'want' relating specifically to clients, 'feeling better'.

1.2.1. 'Feeling better'.Participants consistently described wanting patients to feel better by the end of therapy, irrespective of therapy goals. The following extracts demonstrate both the general hope that patients would 'feel better', and what 'feeling better' might entail:

P4: "I want them to feel better, I want them to go away feeling that there's been some change and that's a change for the better."

P5: "There's something about just helping somebody to function a bit better, to beat themselves up a bit less, to be a bit more stable."

In summary, analysis identified distinctions between therapist-specific 'wants', and client-specific 'wants', perhaps indicating an awareness on the therapists' part of potential discrepancies between their own initial session 'wants' and those of their clients. Two initial session 'wants' emerged specific to therapists, relating to managing expectations and creation of rapport and alliance. Further discrepancies emerged between participants' own expectations for therapy and those of their clients, carrying implications for supervision. Participants consistently identified one initial session 'want' relating to clients, specifically that they would be 'feeling better' by the end of therapy.

2. Defining 'recovery'. Defining 'recovery' consisted of four level two themes: complexity; therapy-specific cues; service recovery; and clinical recovery.

2.1. Complexity. When attempting to define 'recovery', participants voiced a range of complexities relating to the use of outcome measures, social factors, and patients' individual characteristics.

The following extracts demonstrate the complexities highlighted by participants about the use of outcome measures. In particular, participants consistently identified complexities around how patients complete measures, and the impact of exposure work in treating anxiety disorders:

P4: "You can have somebody who's really low and depressed and anxious…and they fill in the forms and you think 'oh that doesn't look that bad' so it depends how we fill forms in doesn't it?"

P1: "If they're going to start doing things that they've been avoiding because they've felt anxious their anxiety scores are going to go up

whereas actually we would say they're getting better because they're starting to do the things that they've been avoiding but the measures are saying they're getting worse."

In addition to the complexities around completion of measures, participants also identified complexities around patients' social situations and broader social/political factors that impact on patients' recovery:

P12: "When they were talking [during training] about caseness and recovery rates dropping I remember having a conversation then with people about 'but it's so much more than that'…you can't stop all those social factors or those other things that come in in the meantime."

P3: "If you're an asylum seeker and your application is refused and you're struggling even to feed yourself it's going to be a lot harder to feel non-depressed than someone who has a really supportive family environment, the society respects them…you have to accept it's society as a whole that affects recovery as well as you."

P15: "People's lives are much more three dimensional than can be captured in [measures], there's an awful lot going on in their backgrounds which are going to start them off in a different place anyway I think, let alone…people's characteristics and personality traits."

In summary, complexities identified by participants around defining 'recovery' focused on the use of outcome measures, patients' social situations, and broader social/political factors, including individual personality traits. However, it is possible that clinicians' perception of complexity in relation to patients' recovery constitutes a framework that mitigates against failure either to treat or to achieve the service-based definitions of recovery (as based on outcome measures) by the end of therapy.

2.2. Therapy-specific cues.Participants referred to a range of therapy-specific cues to help with the assessment or definition of 'recovery'. The most frequent cues identified related to use of goals and completion of homework, both as a potential indication of recovery, and to guide future work:

P3: "Signs of recovery, (pause), I think putting more and more impetus on them doing their own homework, really getting on board, achieving the goals they want to achieve so another really important part about monitoring recovery is reviews so you have time to look at 'let's look at your goals are you progressing with them?'"

P6: "The protocols might inform me also about my thoughts on someone's recovery and I suppose I'd be thinking about, 'okay well is this person now able to do this?' or 'can they now do this?' and 'can they look at challenging their thoughts?' and that type of thing."

In addition to goals and homework, participants also referred to changes in patients' presentation in sessions as an indication of recovery. The following extracts demonstrate how therapists gauge recovery using changes in patients' demeanour and general presentation:

P4: "When they're feeling better they might be a bit more chatty as they leave the room or as they come into the room so a sense that theydon't just need to talk about their problem all the time, that has faded a bit and they can talk about other things as well."

P17: "One woman I worked with last year initially would describe things in a hurried way and then she just started to have pauses in between her words and just be able to be a bit more reflective."

In summary, therapists identified use of therapy-specific cues as beneficial in assessing patients' recovery. Therapist assessment of recovery

drew on information from goal sheets, completion of homework, and changes in patients' demeanour and presentation during sessions. It is possible that use of therapy-specific cues to assess recovery also facilitates ongoing management of both therapists' and clients' expectations of what might be achieved by the end of therapy, through direct monitoring of goal attainment and patient change.

2.3. Service recovery.When defining 'recovery', all participants referred to the service definition of recovery, as demonstrated in the following extracts:

P14: "The way we define recovery in IAPT really it's quite narrow in terms of talking about recovery rates and reduction on clinical measures."

P9: "Our service like any is performance driven…we look at move to recovery rates which is being nine or less on the PHQ9 or seven or less on the GAD7 or below the thresholds for anxiety specific indicators."

*2.3.1. Tension.*Participantsidentified a range of tensions arising from the definition of 'recovery' encompassed by service definitions. One of the main tensions related to discrepancies between broader indications of 'recovery' and the narrow definition of 'recovery' set by the service (based on cut-off scores), with a perceived pressure to ensure that patients score below cut-off by the end of therapy:

P2: "If you've got a patient scoring21 on the PHQ9, if they got down to 12 I'd think that was a huge improvement, but in terms of the measures they wouldn't be classed as in recovery, whereas I would be suggesting if they were back at work and they were doing all those things that maybe a patient with lower scores were doing just because the scores weren't in recovery, I'd still be saying 'yeah that's that patient's in recovery.' I think that's when the pressure then comes to go 'right do I keep seeing this

patient to get the scores down so they're not just in recovery themselves but they're also in the service recovery?'"

Participants identified a further tension in relation to the use of recovery rates. The following extracts summarise the impact that referring to recovery rates can have on both a personal level, and on decisions about starting and ending episodes of care:

P10: "I don't tend to look at my recovery rates very often, just because I know I have some difficult surgeries and if I look at them on a certain day they're good, for those few months I feel good but if they're not it will probably make me feel a bit bad. "

P17: "I'm not aware of my recovery rates because I deliberately don't look. It's more the organisation, it's more managers saying 'you need to do this and you need to get the waiting list down...' but have I changed my practice? (Pause) I can only think of that in that I would I have at times been a bit more abrupt in ending care."

P9: "Recovery targets tend to play a bit more about decisions on who you see and how long you see them for. So if you didn't have the targets you might take on people who were less likely to recover."

The following two extracts illustrate the tensions that perhaps prevent reconciliation of recovery rates, the service definition of 'recovery', and patients' perceptions of their own recovery:

P16: "What I don't want to lose sight of is that we're human, our clients are human and maybe according to the scores someone hasn't got below caseness but…their perception of how they are and their description of how they are is loads better. But on a tick box and adding up the numbers it looks as though they haven't really changed very much

but if you were scoring…29 on a PQ9 and you're now scoring 16 that is a massive change but it doesn't actually meet recovery."

P8: "Recovery is, as we hold it as a service, our commissioning targets, and…has to be something measurable, we all understand that, I think when you throw real people with real life experience into the mix, recovery for those patients is probably different to an outcome on the clinical measure."

Whilst recognising the potential negative impact that focusing on recovery and recovery rates can have on therapists, some participants expressed a sense of hope that an alternative perspective of recovery rates might develop given the opportunity and motivation:

P8: "Recovery, in certain circumstances, it's been used as a bit of a stick to beat us with so we've all become a little bit wary of it, I'm hoping that we can change that just by…getting interested and excited about it and having a bit of a different perspective and approach to it."

In summary, all participants referred to the service definition of 'recovery' when invited to define 'recovery'. However, participants identified a range of tensions arising from the definition of 'recovery' encompassed by service definitions. These tensions related to discrepancies between broader indications of 'recovery' and the service definition of 'recovery'; perceived pressure to ensure that patients score below cut-off on measures by the end of care; the personal and professional impact of referring to recovery rates; and difficulties reconciling recovery rates, service definitions of 'recovery', and patients' perceptions of their own recovery. Participants consistently expressed dissatisfaction relating to the way in which improvements on scores on outcome measures are often overlooked when scores remain above clinical cut-off. This

dissatisfaction might be remedied by wider use of reliable and clinically significant change in patients' scores on measures to define recovery and recovery rates. Despite the tensions identified, participants expressed a sense of hope that recovery rates might be viewed more positively given the right circumstances.

2.4. Clinical recovery. As an alternative to service definitions of 'recovery', analysis indicated that participants drew on definitions of recovery that could be summarised as 'clinical recovery'. This theme yielded three level three themes: symptom changes/improved quality of life; self-reported changes; and recovery journey.

2.4.1. Symptom changes/improved quality of life. Participants drew on medical perceptions of recovery, and changes in patients' presentation and understanding of their difficulties to define 'recovery', as the following extracts illustrate:

> *P3: "If you understand the more medical perception of recovery and you take depression it's getting to the point where people have fewer of the symptoms of depression…their sleep settles a bit, they don't hate themselves as much, they're not wanting to kill themselves, they're not having as many negative sad thoughts about themselves, they're getting more pleasure and reward from activities…For anxiety, recovery is about being able to have the symptoms of anxiety but understand what they mean."*
>
> *P12: "Often you see a change in body language, how they talk and their understanding of the problem, their emotions, [and] expressions."*
>
> *P17: "Quite often it will be in their face. There's usually a different expression…especially when someone's anxious…when you first meet*

someone in the waiting room you can see that startled pigeon look in their eyes and then as their anxiety comes down their features and everything just become less (pause) frozen."

Alongside symptom reduction, participants referred to improvements in patients' quality of life to define 'recovery':

P1: "Recovery might be about helping people to engage in their life again, in meaningful activity and to improve their quality of life and in whatever picture that means to them."

*2.4.2. Self-reported changes.*Participants consistently referred to patients' own perceptions of whether they were in recovery as a way of defining 'recovery'. Self-reported changes were often felt to be corroborated by participants' own perceptions of patient change:

P4: "I base a lot of it on what they're sort of telling me and that usually sort of marries up, they usually say they're a lot better than they were and I'm thinking 'yes you are a lot better.'"

P17: "They start to report improvements in relationships, in expressing their feelings and talk about taking risks and risks having paid off."

P4: "They're reporting that they feel better, more able to cope with events, with emotions, feeling stronger, feeling in a better place."

*2.4.3. Recovery journey.*When defining 'recovery', participants emphasised that recovery was an ongoing process, as opposed to a discrete event. Whilst some used metaphor to illustrate their point, others spoke about recovery as a "management process" or "journey":

P1: "Sometimes looking after our wellbeing's like gardening…sometimes there's loads of work, everything needs digging up and cutting back… other times you can just sunbathe and enjoy all the flowers…looking after

anxiety or depression can be a bit like that. There's times in our life where we've got to put a lot of work into looking after ourselves and there's other times when we're quite well."

P2: "I think [recovery's] kind of a management process, it's ongoing. I think people will always be concerned once they've suffered with anxiety or depression that it might come back and I think that's incredibly normal, because they've had a really rubbish time so I think it's an ongoing process."

P17: "I think recovery implies that a task has finished and it's over and done with, job done, but I think that certainly when I'm working with clients, it's a journey that we go with our clients to a certain point and we leave them at that point and then sometime in the future we might return to that client and they'll be at another point in their journey."

In addition to patients' own recovery journeys, some participants spoke about following a recovery journey themselves, characterised by a changing relationship with the concept of 'recovery':

P15: "When I started out I probably had a far more romantic idea that a lot of change might happen through therapy, and now I'm a lot more, I was going to say cynical. I'm not cynical I'm just perhaps more realistic about it."

P8: "When I came in as a brand new trainee and they started to talk about recovery rates I was thinking 'ooh there's a way to measure how good I am' (laughs)…once I started to work with actual people…I realised I was going to struggle to achieve the 50% recovery rate with the client groups I was working with...and [now] I've matured into the

role...looking at mitigating factors for each of the things that can affect recovery and…my recovery rates have gone up."

In summary, participants suggested 'clinical recovery' as an alternative definition to service definitions of 'recovery'. 'Clinical recovery' incorporated symptom changes and improved quality of life; self-reported changes, which were corroborated by participants' own perceptions of patient change; and recovery as an ongoing process or "journey" undertaken by patients and therapists alike.

3. Meaning of 'recovery' to patients. Participants' responses to questions around the meaning of 'recovery' to patients yielded two level two themes: a patient benchmark of 'feeling better', and the importance of recovery. Two further level three themes related to the importance of recovery: symptom reduction, and recovery 'buzz word'.

3.1. Patient benchmark: 'feeling better'.Participants consistently felt that patients' main benchmark for 'recovery' would be 'feeling better':

P1: "Most patients would say 'I'm recovered when I'm feeling better' or…'I'll be better when I can cope with things'."

P8: "I think it's in short feeling better (laughs) and better not being necessarily 100% well but improved on where they started from."

3.2. Importance of recovery.When trying to operationalise what 'feeling better' means to patients, participants referred to symptom reduction and reflected on the value of the term 'recovery' to patients.

*3.2.1. Symptom reduction.*Participants felt that patients' main assessment of whether they were 'feeling better' was predominantly symptom based, focusing on symptom reduction, as the following extracts demonstrate:

P1: "Quite often with anxiety it's about sort of symptom reduction getting rid of the anxiety whereas with depression it's 'I just want to feel better just don't want to feel like this anymore'."

P14: "They want rid of their problem quite often, they want the symptoms to go away and they want to get back to their previous level of functioning."

P11: "Sometimes clients are too symptom focused… say they've got OCD, they're aware that they're cleaning all day or checking or whatever and they want that out of their life…to me recovery would be them living a more satisfied life, to them it's just 'I want to get rid of these symptoms'."

Potential discrepancies between therapists' and clients' perceptions of recovery, as indicated above, perhaps relate to identified discrepancies around managing expectations and initial session 'wants'. Failure to clarify what recovery means to patients carries a risk of failure either to treat or to achieve service recovery (based on outcome measures) by the end of therapy. As such, it could be argued that patient-centred approaches towards recovery are essential to guard against this risk.

*3.2.2. Recovery 'buzz word'.*When considering the importance of 'recovery', analysis indicated that participants considered 'recovery' unhelpful as a concept to patients. In particular, participants voiced concerns about 'recovery' from mental health difficulties as being more complicated than recovery in a physical health context, and 'recovery' as a concept that carried particular "unhelpful" connotations:

P13: "I think for many of them it's fairly useless [as a term]…there's not kind of recovery in the sense that like you get flu and then you don't get

flu, if you've got flu how do you know you've recovered? Well, there's a whole criteria…[with mental health] it's not recovery as people really think of recovery."

P15: "I'm not sure I would ever use the word 'recovery' myself because I think it's got perhaps unhelpful or misguiding connotations. If I was to talk to a client about recovery it might give them misconceptions about what we might be able to do in our sessions."

P3: "I think recovery's a buzz word…I don't think patients use the word 'recovery'. I think it's a service-invented term for what we're all trying to do as humans."

In summary, participants expressed a view that patients assessed 'recovery' as predominantly "feeling better", drawing on reductions in their symptoms of anxiety and depression to define "feeling better". Participants expressed awareness of discrepancies between therapists' and clients' perceptions of recovery, which is of particular importance when negotiating therapy goals and considering what might realistically be achieved by the end of therapy. Participants viewed the concept of 'recovery' as "unhelpful" to patients, considering it a "buzz word".

4. Personal qualities beneficial for promoting recovery. Personal qualities identified as beneficial for promoting recovery yielded two level two themes: therapist qualities, and mutual qualities, which applied equally to therapists and patients. Therapist qualities yielded three level three themes (awareness; empathy; and flexibility); mutual qualities yielded two level three themes (trust/faith; and willingness).

4.1. Therapist.Participants identified awareness, empathy and flexibility as key personal qualities beneficial in a therapist for promoting patient recovery.

*4.1.1. Awareness.*Participants identified a need for awareness in a range of contexts. Being aware of the challenges patients may face when attending therapy for the first time was identified by several participants, and succinctly summarised in the following extract:

P16: "For someone to come and see a total stranger knowing that maybe their perception of what's going to happen, that there may be tears, and if they've built up a resistance to tears or being emotionally open, it's an awfully hard thing for people to do."

Awareness of limits was a further context, both in relation to the limits of what IAPT could provide as a service and in terms of one's own limits as a therapist:

P6: "Not just keeping on going when perhaps this person needs to be stepped up to the CMHT or something…seeing the bigger picture…taking a step back from things not getting caught up with it all."

P3: "The evidence base only gets 50% of people better. I typically only get 50% of people better really, I understand what my limits are; I'm not a heroine, that's not what I'm there to do. I know, though, with some patients for some particular characteristics, it will trigger the heroine response in me so I have to really take that to supervision and check I'm not trying to rescue people."

Awareness of personal recovery rates (despite the perceived tension discussed above) was also identified as beneficial. When combined with an awareness of factors that impact on recovery, some participants felt that awareness of their recovery rates had both changed and enhanced their clinical practice:

P8: "The more I've aimed for a target of 50% recovery and looked at what might be affecting that, the more people have moved into recovery."

*4.1.2. Empathy.*Participants identified empathy as a core quality beneficial for recovery. However, analysis indicated that excessive empathy was perceived as potentially detrimental due to the risk of losing objectivity:

P17: "The first and foremost thing that you need is empathy…You need to be able to empathise with their sadness, feel their sadness, but not take it on as your own sadness so there has to be some way of disentangling yourself, some objectivity about it."

P6: "Being able to empathise with people but there's a fine line…too much empathy could be detrimental…I do and can empathise with people, at the same time I may also take a step back from it too."

*4.1.3. Flexibility.*As with awareness, participants described flexibility as beneficial for promoting recovery in a range of contexts. The essence of IAPT was felt by some to necessitate flexibility in therapists, as demonstrated by the following extract:

P11: "Flexibility because IAPT's forever changing, the GP surgeries are forever changing. No two clients are alike…no two people's depression is ever the same."

Participants felt that the nature of therapy itself required a degree of flexibility on the part of the therapist, to both facilitate engagement and match the therapeutic approach to patient need:

P4: "If they seem to want me to be a bit chatty I've perhaps got to be a bit chatty, if they want me to be a bit quiet I perhaps need to be a bit quieter, I've got to sort of judge what they might need from me to help them to start the process…because I want them to keep coming back."

P13: "It's like you're different with everyone you work with which is kind of an exaggeration butif you come in today and you've got a score of25…your eye contact's not very good and you're in tears, I'm going to be much more gentle and much less challenging than if you've got a score of 13 and you're showing some avoidant behaviour about something."

Similarly, awareness of patients' movement towards recovery was identified as central to both renegotiating the therapeutic contract (to maximise patients' improvement), and revising goals to meet patients' needs:

P16: "Reviewing sort of session four and five if we've contracted for eight sessions, if it gets to session seven and there are clearly issues that are being worked on and there is a slowly moving to recovery then I would renegotiate another, say, four sessions."

P4: "[By extending the therapy contract] they've got a lot better and if I hadn't had that length of time with them…I'd have been sort of leaving them finishing with the point where I don't think they'd have been that much improved."

P6: "Maybe towards when we like review goals something might change because new information might have come to light perhaps and maybe it is more difficult for that person to do certain things that we first anticipated so maybe we might review the goals."

In summary, participants identified awareness, empathy and flexibility as key personal qualities that were beneficial in a therapist for promoting patient recovery. 'Awareness' referred to a range of contexts, specifically awareness of the challenges patients may face when attending therapy for the first time; awareness of the limits of what IAPT could provide as a service, and of one's

own limits as a therapist; and awareness of personal recovery rates and factors that impact on recovery. Whilst empathy was viewed as key personal quality, excessive empathy was perceived as potentially detrimental. Finally, 'flexibility' was perceived by some as essential due to the nature of both IAPT and the course of therapy itself, as was flexibility in terms of renegotiating therapeutic contracts and revising goals to meet patients' needs.

4.2. Mutual. Participants identified trust/faith and willingness as key personal qualities beneficial for recovery in both therapists and patients.

*4.2.1. Trust/faith.*Participants referred to trust/faith in a range of contexts. Trust was perceived as a key component of therapy for both the therapist and patient, as the following extracts demonstrate:

P13: "They've got to have some degree of being able to trust so if they can't trust at all then (pause) if that was the case you couldn't work with them really."

P4: "There is quite a level of trust, in that they can say whatever they like to me and equally sometimes the work means that I'll have to say things to them that might be a bit difficult for them but we should have a good enough relationship to do that."

Participants' own trust and faith that change is possible was also emphasised as playing a key role in helping patients work towards recovery:

P3: "Sometimes I really work on making eye contact with them and saying 'I do this job because I see people get better.' If somebody's looking like they're down a big dark hole trying to connect with them a little bit and give them that hope."

P14: "I genuinely believe people can change things…so a little bit of optimism (pause) and I think probably the fact that I genuinely believe

that, I don't just think that because I've been told that that's something you should do as a therapist."

4.2.2. Willingness. In addition to trust/faith, participants identified willingness as key. In relation to patients, participants felt that willingness to try therapy and take some responsibility for their own recovery was essential:

P1: "In a client it's about willingness to try and do something differently…because even if they don't feel like they can or they don't feel ready or able to do something, if they're willing to give therapy a try and willing to try and do something different then that's a massive thing."

P11: "Being willing to take responsibility for themselves and for their own recovery and their own mental health and sort of seeing it as something that's a life change rather than just a quick fix."

As part of helping patients to take responsibility for their own recovery, participants felt that therapists needed to show willingness to both listen to and challenge their patients:

P1: "Being willing to listen, get a shared understanding…sort of share their world view."

P17: "You need to be able to challenge your clients as well. In a positive way, helpful way, but not collude with them."

In summary, participants identified trust/faith and willingness as key personal qualities beneficial for recovery in both therapists and patients.Trust was perceived as a key component of therapy, particularly in relation to the therapeutic relationship, and in the potential for change. Participants also felt that patients' willingness to try therapy and take some responsibility for their own recovery was vital, facilitated by therapists' willingness to both listen to and challenge their patients.

5. Barriers to recovery. Participants identified a range of barriers to recovery, all of which could be encapsulated in an overarching theme of ‘lack of active engagement’.

5.1. Lack of active engagement.Participants identified a range of factors that they felt impacted on patients’ ability to engage in therapy. The following extracts demonstrate both the variety of factors, and their potential impact on the outcome of therapy:

P7: “Various unhelpful behaviours…alcohol, drugs, if someone’s in a place where they're not ready to engage, if they've come wanting a magic wand to make everything better.”

P1: “[If] somebody’s not coming to their appointments, they keep cancelling, they're not doing the between session work…I’ll start to think, you know, we’re going to struggle to improve things here.”

In contrast to a lack of engagement on the part of the patient, some participants identified a lack of active engagement on their own part. In the following extract, the participant describes the impact that their experiences of childhood bullying had on their ability to actively engage with “aggressive young men”:

P13: “I was kind of bullied at school and so what I've kind of struggled with over the years are, er, tough aggressive young men, and I'm sure I didn’t engage with [such men] ‘cos I couldn’t engage with them really, but now, I can think of one young man who I engaged with seemingly really very well but in the past I'd be absolutely terrified…I guess it’s kind of being aware enough of ‘why don’t I get on with this person? Why do I find it difficult to be authentic with this person?’”

In summary, participants felt that working towards recovery needs active engagement on both the part of the patient and the therapist. Participants also emphasised the role that awareness within sessions ("why do I find it difficult to be authentic with this person?") can play in helping to facilitate patient engagement in therapeutic work.

Quantitative Data Analyses

Table 4 shows participants' overall scores on measures of resilience and empathy. Participants' mean resilience score (as measured by the CD-RISC10) was slighter lower than that of a comparative non-clinical sample. Total, affective, and cognitive empathy scores for both males and females were all higher than those of a non-clinical sample. However, in contrast with the non-clinical sample, male participants' scores on all three empathy scales were higher than female participants' scores.

Table 4.*Overall scores on resilience and empathy measures, and comparative normative data*

Measure	Range	Mean (SD)	Normative data Mean (SD)
CD-RISC10	21-39	28.9 (4.65)	31.8 (5.4)
BES (Total)	71-100	81.65 (7.88)	-
Females	71-91	81.07 (6.79)	75.3 (8.3)
Males	76-100	84.33 (13.58)	64.3 (9.8)
BES (Affective)	35-55	42.65 (5.12)	-
Females	35-49	42.14 (4.38)	40.3 (5.8)
Males	40-55	45 (8.66)	32.1 (6.5)
BES (Cognitive)	32-45	39 (3.84)	-
Females	32-45	38.93 (3.79)	35.0 (3.9)
Males	36-45	39.33 (4.93)	32.2 (5.1)

Table 5 shows scores on measures by professional group. Whilst CBT therapists had the highest levels of resilience, PWPs had the highest levels of empathy across all three areas. However, statistical analysis of group differences was not possible as the number of participants within each professional group meant analysis would be underpowered to reach any meaningful conclusion.

Table 5.*Scores on measures of resilience and empathy by professional group*

	Professional Group					
	CBT therapist		Counsellor		PWP	
Measure	Range	Mean (SD)	Range	Mean (SD)	Range	Mean (SD)
CD-RISC10	27-39	32.4 (5.27)	24-34	28.83 (3.97)	21-29	26 (2.97)
BES (Total)	76-85	80.2 (4.09)	71-100	80.17 (10.63)	72-91	84.33 (7.69)
BES (Affective)	36-46	40.6 (3.98)	35-55	43.17 (6.97)	37-49	43.83 (4.07)
BES (Cognitive)	37-43	39.6 (2.41)	32-45	37 (4.29)	35-45	40.5 (4.04)

Chi-squared tests for independence were conducted to investigate whether therapists' personal qualities (resilience and empathy) affected identified themes. 'Expected' cell values were calculated by converting the percentage of participants identified as having 'high' or 'low' empathy and resilience to numbers for each theme identified (see Table 6).

Table 6.*Example of Chi-squared analyses frequency tables*

Theme (N)	Observed	Expected*	χ^2	*P*
Complexity (13)				
High resilience	6	6.12	.004	.945
Low resilience	7	6.88		
Therapy-specific cues (14)				
High resilience	6	6.59	.100	.752
Low resilience	8	7.41		
Tension (15)				
High resilience	7	7.06	.001	.975
Low resilience	8	7.94		

*47.06% participants identified as 'high' resilience; 52.94% participants identified as 'low' resilience.

A significant difference in therapists' rates of cognitive empathy was identified in relation to 'complexity' (χ^2= 4.23; p = .039), with significantly more therapists classed as having high cognitive empathy describing complexity in defining 'recovery'. No further results indicated significant differences (see Appendix 15).

Discussion

Recent research has identified significant differences between clinicians' and patients' perspectivesof what is important in being in recovery from depression (Demyttenaere, et al., 2015). The present study sought to further investigate clinicians' perceptions of patient recovery from mental health difficulties, to inform clinical practice and influence future research.

Analysis of participants' responses to questions about initial session 'wants' identified a key distinction between therapist- and client-specific 'wants'. Whereas therapists prioritised management of expectations and the formation of therapeutic relationships, therapists felt that the main 'want' for clients was to feel better. A similar distinction emerged between therapists' definitions of recovery, and therapists' perceptions of what recovery means to their clients. Specifically, therapists identified complexities and tensions in their definitions of recovery, which contrasted with their perception that clients would define recovery as 'feeling better', neither of which was necessarily reflected in goals for therapy.The conflict between the perception of complexity arising from therapists' definitions of recovery versus the simplicity of clients' perceived definitions ('feeling better') might be reconciled in part by interpreting clinicians' perception of complexity as a framework that mitigates against failure either to treat or to achieve the service-based definitions of recovery (as based on outcome measures) by the end of therapy.This interpretation is particularly pertinent when considering the IAPT context that this study is based in, where numerical outcome data is considered the main tenet of recovery rather than focus on recovery narratives (McPherson, Evans, & Richardson, 2009; Williams, 2015).

Therapists identified the role that creating rapport and alliance plays in both managing expectations of therapy, and facilitating movement towards recovery. This mirrors findings by Badger and Nolan (2005) that primary care patients perceived responsive and caring practitioners as playing a key role in their recovery from depression. Furthermore, participants in this study emphasised the need for awareness of the challenges patients may face when attending therapy, combined with awareness of the limits of what IAPT could

provide as a service,which supports research by van Grieken et al. (2014) that highlighted the need for clarity and consensus about the nature of treatment for depression, availability of appropriate mental health care, and secure relationships with clinicians.

Consistent with the findings of a recent review of the literature relating to patients' and clinicians' perceptions of recovery from depression (Richardson, 2016), this study found that clinicians perceived recovery as a complex, personal process that is influenced by a range of factors, including patients' social situations, and social/political and personality factors. In particular, participants' emphasis on the impact that patients' personality factors, social situations, and access to support can have on recovery, mirrors earlier research findings that identified associations between social support and recovery from depression (George, Blazer, Hughes, &Fowler, 1989; Gladstone, Parker, Malhi, & Wilhelm, 2007; Vidler, 2005).

All participants referred to the service definition of 'recovery' when invited to define 'recovery'. However, participants emphasised a range of complexities and tensions that arise from sole use of service definitions of recovery (i.e., outcome measures and cut-off scores), mirroring those identified by Williams (2015). In particular, participants' perceptions that outcome measures do not capture patients' social situations, individual personality traits, or perceptions of their own recovery, reflects Williams' concern that the measures used within IAPT to assess recovery do not reflect the reality of depressed or anxious states.Furthermore, research has identified that normalised, biomedical, symptom-based definitions of recovery (as captured in outcome measures) are not supported by patients (Emslie, et al., 2005; O'Brien, 2012; Schreiber, 1996).

Participants' assessment of client recovery using symptom changes and improved quality of life is consistent with the physicians' perspectives identified in Demyttenaere et al.'s (2015) research.Participants' perspectives of what patients would consider important in being in recovery from depression (i.e. 'feeling better') was also consistent with Demyttenaere et al.'s research, which indicated that patients focus on restoration of positive affect.

Limitations and Recommendations for Future Research

To the author's knowledge, this study is the first to investigate IAPT therapists' perceptions of client recovery, and associated factors. Replication of the findings with a larger sample size is therefore essential, to assess whether the themes identified are representative of IAPT therapists across the country. However, a particular strength of this study is the equal representation across the three professional groups, with the final template providing a detailed account of IAPT therapists' perceptions of client recovery, and associated factors.

The participants included in this study all responded to invitations to participate. Whilst each of the professional groups was equally represented, the sample predominantly consisted of female therapists. It is therefore possible that the sample is not wholly representative of therapists within IAPT. It could also be argued that only those therapists with strong views about client recovery volunteered to participate. If so, this might reduce the potential to gain an understanding of therapists' perceptions that could be generalised to the IAPT service as a whole. Future research would therefore benefit from using randomised sampling techniques.

Consistent with previous research into therapist effects and patient outcomes (Green et al., 2014; Pereira, 2014), this study used a mixed methods

design. Use of Chi-squared tests of independence enabled tentative investigation of associations between therapists' personal qualities (empathy and resilience) and themes contained in the final template. This strategy provided a more robust assessment of associations than that provided by observation alone. Whilst this approach might be considered innovative, it nevertheless carries inherent limitations, such as the risk of Type II errors due to the small sample size. Furthermore, the approach only identifies associations between themes and measures of individual difference. It is therefore not possible to establish whether themes such as complexity emerged solely due to participants' high levels of cognitive empathy or whether other factors came into play. Replication is therefore essential, both in terms of the final template and the tentative associations between cognitive empathy and complexity as a theme.

Participants' scores on measures of empathy indicated consistently higher levels of total, affective, and cognitive empathy compared with normative data. Furthermore, in contrast with normative data and wider research (Jolliffe& Farrington, 2006), male participants reported higher levels of empathy than females. Due to the small sample size in this study, these findings must be treated with extreme caution. However, replication of these results might provide an insight into the personal qualities of therapists working within IAPT, both in comparison with the general population and between the two genders working in IAPT.

The finding that participants expressed a range of tensions and complexities relating to definitions of recovery that were based solely on outcome measures and cut-off scores warrants further investigation. In particular, future research should assess the validity of recovery as measured

by the GAD-7 and PHQ-9, due to existing research suggesting that patients do not support the normalised, symptom-based definitions of recovery captured in these measures (Emslie, et al., 2005; O'Brien, 2012; Schreiber, 1996).

Finally, the researcher acknowledges that template analysis, along with other methods of qualitative research, is an interpretive process (King, 2004). The researcher therefore acknowledges that their interpretations will have been influenced by their experiences and knowledge. As future research using qualitative research methods will also have this limitation, research designs that employ both qualitative and quantitative research methods are recommended.

Theoretical and Clinical Implications

By developing a greater theoretical understanding of therapists' perceptions of client recovery from mental health difficulties, this research has tentatively identified the processes used by therapists to assess recovery. In turn, this carries potential implications for supervision and training to support therapists in assessing both clients' progress throughout therapy, and client recovery from mental health difficulties.

Recognition needs to be given to the perceived personal and professional impact that referring to recovery rates has on individual therapists. In particular, participants expressed concern that the emphasis placed on recovery rates in supervision both fails to acknowledge the fact that both they and their clients are human, and affects the clinical decisions that therapists make in relation to ending therapy (either prematurely, to meet service demands, or extending episodes of care to achieve service recovery). Practitioners in supervisory roles should therefore actively explore the impact that referring to recovery rates is having on individual therapists, with a

particular focus on identifying and addressing associated implications on their clinical practice and decisions.

Results also indicate clinical implications for IAPT as a service, and the way in which recovery is defined. Participants' definitions of recovery demonstrate that recovery as measured by IAPT does not reflect recovery as defined by therapists. Consideration should be given to wider use of reliable and clinically significant change in patients' scores on measures to define recovery, as opposed to use of clinical cut-off scores. In addition, examination of therapists' and clients' 'wants' and expectations of therapy in supervision would ensure that identified therapy goals are representative of both what patients want and what is clinically indicated, such that recovery is personalised.

Finally, application of the findings to other areas of clinical practice requires consideration of the context from which these findings were generated. Within IAPT services, 'recovery' is specifically defined and based on clinical cut-off scores on condition-specific measures. As such, participants' responses were arguably influenced by their work environment. This influence is central to understanding this study's findings, as the tensions and complexities identified by participants when defining 'recovery' are potentially unique to IAPT services. If so, this study's findings may only transfer to other clinical settings that are commissioned to meet specified recovery targets. However, the findings relating to initial session 'wants', perceptions of what recovery means to clients, personal qualities beneficial for facilitating recovery, and barriers to recovery, would arguably apply as equally in a clinical psychology service and an IAPT service.

Conclusions

The present study sought to investigate IAPTtherapists' perceptions of patient recovery from mental health difficulties. Analysis of participants' transcripts yielded five superordinate themes relating to: initial session 'wants'; defining 'recovery'; the meaning of 'recovery' to patients; personal qualities beneficial for promoting recovery; and barriers to recovery. The study found that participants perceived recovery as a complex, personal process that is influenced by a range of factors. Furthermore, participants consistently identified a range of tensions and complexities relating to use of service definitions of recovery, preferring to use alternative, clinically-based definitions of recovery. However, further research is needed to assess the applicability of this study's findings to IAPT services nationally.

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Appendices

Appendix 3.University ethical approval

---------- Forwarded message ----------
From: Psychology Research Ethics Application Management System <no_reply@psychologyresearchethicsapplicationmanagementsystem>
To: M.Barkham@sheffield.ac.uk
Cc:
Date: Wed, 15 Apr 2015 20:59:15 +0100
Subject: Approval of your research proposal
Your submission to the Department of Psychology Ethics Sub-Committee (DESC) entitled "Investigating therapists' perceptions of recovery in Improving Access to Psychological Therapies services" has now been reviewed. The committee believed that your methods and procedures conformed to University and BPS Guidelines.

I am therefore pleased to inform you that the ethics of your research are approved. You may now commence the empirical work.

Yours sincerely,
Prof Paul Norman

Acting Chair, DESC

Appendix 4.Participant information sheet

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS
research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

Participant Information Sheet (03/08/2015)

Title of Project: Investigating therapists' perceptions of recovery in Improving Access to Psychological Therapies services.

Name of Researchers: Katy Richardson, Professor Michael Barkham

Thank you for taking time to read this. We are inviting you to take part in a research study investigating your perceptions of client recovery from mental health difficulties. This research project is conducted as part of a Clinical Psychology Doctoral training programme.

Before you decide whether you would like to take part it is important you understand the purpose of the research and what your participation would involve. Please take time to read the following information carefully and before deciding whether or not you wish to take part. Please contact us if you have any questions or would like more information.

If you choose to take part you will be provided with a copy of this information sheet and your signed consent form.

What is the purpose of the study?

The purpose of this study is to investigate therapists' perceptions of client recovery from mental health difficulties in IAPT services.

Who is taking part?

We are inviting low or high intensity CBT therapists, Psychological Wellbeing Practitioners and Counsellors/Counsellors for Depression working within IAPT services to participate in this research.

Do I have to take part?

Your participation in this research is completely voluntary. If you choose to participate you are free to withdraw at any point without giving a reason, and any data collected will be destroyed.

What will happen to me if I take part?

If you choose to participate in this research the researcher will meet you at a location of your choice, where you will participate in an interview which will last for a maximum of 30 minutes. During the interview, you will be asked questions about your perceptions of client recovery from mental health difficulties. These questions are designed to allow you to give open answers and respond in-depth with your thoughts. You will also be asked to complete brief measures of empathy and resilience. Interviews will be audio-recorded and transcribed. Once the interview has been transcribed you will be offered an opportunity to view the transcript to confirm that it is a true reflection of the interview.

What are the possible benefits of this research?

There may be no direct benefit to you as an individual in taking part in this research. You may gain a deeper understanding of your perceptions relating to client recovery, which could translate to your clinical practice. You will not be provided with any incentives to take part in this research.

Are there possible risks of taking part in this research?

We will be asking you to share thoughts relating to perceptions of client recovery from mental health difficulties. Talking about this topic may lead you to think about it more, and reflect on your own effectiveness as a practitioner. This might potentially be distressing. However, you do not have to answer any questions unless you choose to, and you can end the interview at any stage without giving your reasons.

Will I be recorded, and if so how will the recorded media be used?

The interview will be recorded using an encrypted digital audio recorder, which is password protected. The digital recorder will be stored in a locked filing cabinet to which only the researcher has access. Digital, password protected, audio files will also be stored in encrypted files on the researcher's laptop. The laptop will be stored in a locked filing cabinet to which only the researcher has access. Pseudonyms will be used in the transcript, of which all paper copies will be stored in a locked filing cabinet to which only the researcher has access. After a period of one year, the researcher will delete all personally stored audio recordings and destroy any paper versions of data. An anonymised copy will be stored in the research site file.

What if I change my mind?

You are free to withdraw your consent to take part in this research at any time without giving your reasons. Any data collected will be destroyed.

What happens if something goes wrong?

This research project is conducted as part of a Clinical Psychology Doctoral training programme.If you have any concerns about this project, please contact the researcher or the project supervisor, Professor Michael Barkham on 0114 2226527, who will do their

best to answer your questions. If they are unable to respond in an acceptable way and you wish to make a complaint please contact: Sarah Radgick on 0114 2226650 or at the Clinical Psychology Unit, Department of Psychology, The University of Sheffield, Western Bank, Sheffield, S10 2TN.

If you feel that your complaint has not been handled to your satisfaction following this, you can contact the University's Registrar and Secretary Dr Philip Harvey, Email: registrar@sheffield.ac.uk and Tel: 0114 222 1101.

Will my participation in this research be kept confidential?

All personal information collected about you during this research will remain confidential. Your personal identifiable information will be stored separately in a locked and secure location, and destroyed on completion of the research. The Research Supervisor will have access to the audio files and transcripts, but all personal identifiers will have been removed. Your name will not be used for analysis or in writing up and you will not be identifiable. If you provide consent for use of anonymous quotations from your interview, you will be offered an opportunity to read the results section and request to remove any quotations you believe may lead to your possible identification.

What will happen to the results of the research?

It is the intention of the researchers to publish the results of the research in a scientific, peer reviewed journal. If you would like a summary of the results please let us know.

Who should I contact if I have a question or need more information?

Katy Richardson
Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield
S10 2TN

Email: klrichardson1@sheffield.ac.uk

Alternatively, you may contact Ms Sarah Radgickat the University of Sheffield on 0114 2226650.

This proposal has been reviewed and approved by the Department of Psychology, University of Sheffield Ethics Committee. The University's Research Ethics Committee monitors the application and delivery of the University's Review Procedure across the University.

Thank you for agreeing to take part in this research

Appendix 5.Participant consent form

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS
research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

Version 3: 23/02/2015

Title of Project: Investigating therapists' perceptions of recovery in Improving Access to Psychological Therapies services

Name of Researchers: Katy Richardson, Professor Michael Barkham

Participant Identification Number: **Please initial box**

1. I confirm that I have read and understand the information sheet dated …….. explaining the above research project and I have had the opportunity to ask questions about the project. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. ☐
3. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. ☐
4. I give permission for anonymous quotations from my responses to be used in the research report. ☐
5. I agree for the interview data collected from me to be used in future research ☐
6. I give permission for members of the research team to access information relating to my outcome data **(optional).** ☐
7. I agree to take part in the above research project. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

Appendix 6.Email invitation to participate in the study

Department Of Psychology.

Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

VIEWS OF PATIENT RECOVERY: INVITATION TO PARTICIPATE

We are writing to you in your role as a **CBT therapist, Psychological Wellbeing Practitioner, or Counsellor.** We are seeking 10-20 volunteers to take part in a short interview investigating **perceptions of patient recovery** within the IAPT service.

This research forms part of a Clinical Psychology Doctoral research project carried out by Katy Richardson and supervised by Michael Barkham. The aim is to investigate perceptions of patient recovery held by CBT therapists, Psychological Wellbeing Practitioner, and Counsellors working in the Sheffield IAPT service. It is hoped that the results will support the IAPT service in enhancing its patient recovery rates.

Participants will be invited to attend a **single interview, lasting a maximum of 30 minutes.** Interviews will take place at a location of your choosing with the aim of minimising demands on your time. The interview will focus on questions about **your views and perceptions of patientrecovery** and therefore provides a unique opportunity for you to present your own personal and/or professional views. The questions are designed to allow open-ended and in-depth responses. In addition, participants will also be asked to **complete two brief measures**.

Participation is entirely voluntary and participants will be able to withdraw at any time. This research proposal has been approved by the Department of Psychology Ethics Committee at the University of Sheffield, received local NHS Research and Development governance approval, and been endorsed by the IAPT Senior Managers.

We very much hope you will be willing to participate in this research. If you are interested, ***please email Katy Richardson (klrichardson1@sheffield.ac.uk)***

We look forward to hearing from you – Thank you: Katy Richardson & Michael Barkham

Appendix 7.Copy of the Basic Empathy Scale (Jolliffe& Farrington, 2006)

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Appendix 7 - continued.

Content removed to comply with copyright requirements.

Appendix 8.Copy of the Connor-Davidson Resilience Scale-10 (Campbell-Sills & Stein, 2007)

Content removed to comply with copyright requirements.

Appendix 9.Interview schedule

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS
research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

Investigating therapists' perceptions of recovery in Improving Access to Psychological Therapies services

Name:

Age:

Gender:

Job Title:

Years of experience in IAPT services:

Time spent in current role:

I am interested in your perceptions of client recovery from mental health difficulties in IAPT services. It is up to you to decide what you choose to tell me. If there are any questions you would prefer not to answer, let me know. Everything you do tell me will be kept confidential. The interview will take approximately half an hour, depending on how much you want to share. We can take a break at any point. If at any point you want to terminate the interview and withdraw from the study, you can let me know.

BACKGROUND INFORMATION

1. When a patient comes to you for therapy, as a practitioner what are your 'wants' for them?

RECOVERY

2. Thinking about recovery now, what does ‘recovery’ mean to you as a therapist?

Prompts: When would you consider a client to be ‘recovered’? What sort of cues do you look for in your patients to assess their progression towards recovery?Is your definition based on subjective or objective information, e.g. client self-reports, scores on outcome measures? Do these cues differ according to mild, moderate or severe presentations?

3. What do you think ‘recovery’ means to your patients?

Prompts: Thinking about the last five patients you’ve worked with, what do you think would be their benchmark for assessing whether they were recovered? What would you consider to be the most important elements of recovery for your patients?

4. What personal qualities do you think are beneficial for promoting recovery? These can relate to clients and/or therapists.

ENDING QUESTIONS

5. Is there anything that you would like to ask me, or anything that occurred to you during this interview that you think would be important for me to know?

Thank you for taking the time to take part in this interview and for your thoughtful responses. Your input is greatly appreciated.

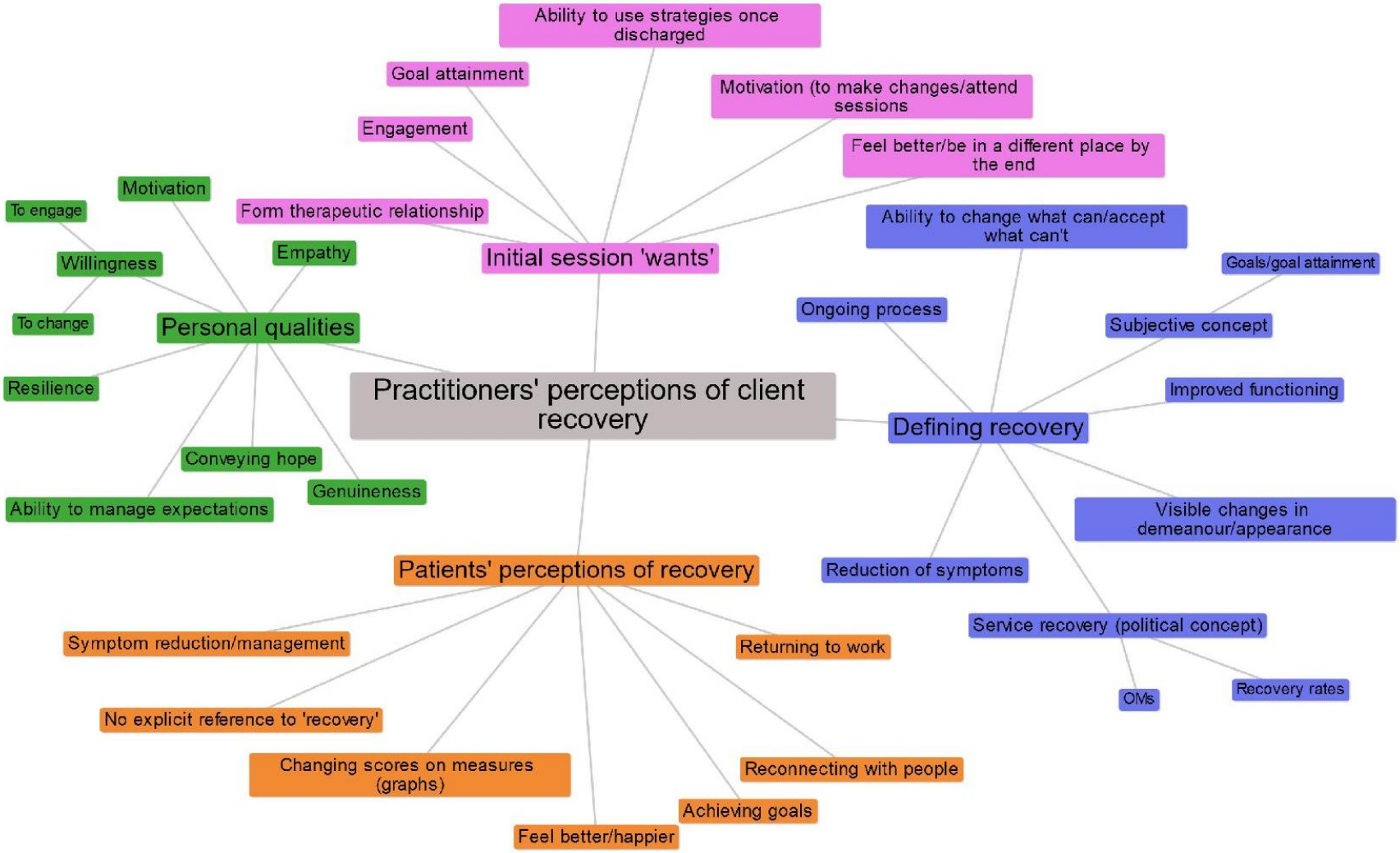
DEBRIEF

6. Was the interview as you expected?

7. Do you have any worries or concerns that have arisen from the interview?

Respond to any distress as appropriate.

Appendix 10.Conceptual map of *'a priori'* themes



Appendix 11.Transcript extract to illustrate coding

Level One Code	Transcript		Level Two Code	Level Three Code
	I:	When a patient comes to see you what are your hopes for them as a practitioner? What are your wants for them?		
Initial session 'wants'	P:	Erm, to, at the end of the episode of care, be feeling better than they are when they come really. And function better.	Client-specific	'Feeling better'
	I:	So feeling better, functioning better. Any other hopes for them?		
Initial session 'wants'	P:	Erm, I hope to have a good relationship that gets helps to get them to that position, erm, I try to be really open minded really and, erm, you know, just kind of listen to what they're telling me really.	Therapist-specific	Alliance/rapport
	I:	What would you need in order to be able to explore what's bringing them to counselling do you think?		
Initial session 'wants'	P:	The opportunity to build up that initial rapport for them to feel comfortable working with me, erm, obviously we we use contracting to set out, erm, at the start of the session and, erm, that would include me giving the client an understanding of the fact that it would be counselling for depression and, in a sense their consent to (pause) to do the work.	Therapist-specific	Alliance/rapport
	I:	So moving on to think a bit about recovery, what do you think the term 'recovery' means to you as a therapist? How would you define recovery?		
Defining 'recovery'	P:	For me it's about (pause) acceptance of being able to change what we can change or enable the client to understand and trust what they're feeling, erm, (pause) for appropriate change, erm, and again as I've said the acceptance of, actually maybe I can't change this, or I certainly, erm, the decision I made with the evidence I had five years ago has changed and how I come to terms with it so it's about, erm, (pause) hmm, client growth, client acceptance of change… I suppose one of the nice things is a we always say that counsellors are non-judgemental but of course we're as judgmental as anyone else and we perhaps notice and we're *curious* about our clients and therefore if someone has come in and for two or three	Clinical recovery	Symptom changes
Personal qualities			Therapist-specific	Awareness/curiosity

Level One Code	Transcript	Level Two Code	Level Three Code
Defining recovery	sessions they've been slumped in the chair and their responses have been non-committal and then they come in and, erm, unless it's really appropriate but they've, you know, if it's someone who's got make up on, erm, and straighten themselves up, just by people's demeanour really and sometimes people will come in and almost before they've sat down they'll say '(sighs) I am just feeling so much better and X Y Z has happened.'	Clinical recovery	Symptom changes
Defining recovery		Clinical recovery	Self-report
	I: So how they look as well as what they're actually saying to you.		
Defining recovery	P: How they look, what they're saying, how they're sounding. I mean clearly we do have the outcomes, erm, and the scores may well have changed, erm, and I, where it's appropriate, tend to let the clients see what has changed in their scores because sometimes it's hard to remember how we felt several weeks earlier.	Service recovery	Tracking change
	I: And thinking about recovery in relation to your patients, what do you think recovery means for them?		
Meaning of recovery to patients	P: [Patients] just want to feel better, don't want to be depressed or anxious anymore. Er, typically they come in because it's got to a breaking point like they want a promotion in work they can't get it or they lost their job so they typically there's a life event that brings it to the fore and they just want to be their, their old selves again. Typically they just want don't want to feel this way anymore…(Sighs) when asked, 'what do you want to get out of counselling?' 'To feel better'. So I guess they they'd they'd say 'feel better' and I suppose 'feel better' is very very idiosyncratic really from their perspective really yeah, yeah, erm ... actually, recovery, as a word in in in that context well I don't know I'd not thought of it until you'd kind of raised it is like actually it's not as black and white as that, it's not like getting flu, you know, if you've got flu how do you know you've recovered? Well, you know, there's a whole criteria, it's like actually it might be nothing, I'm functioning better, you know, for forfor a chunk of lifetime not not just for one episode of illness	Patient benchmarks	Feeling better
Meaning of recovery to patients		Patient benchmarks	Feeling better
Defining recovery		Importance of recovery	Recovery 'buzz word'

Level One Code	Transcript		Level Two Code	Level Three Code
	I:	And are there any personal qualities, either in yourself as a therapist or your patients, that are beneficial for recovery?		
Personal qualities	P:	[Pause] Empathy that's the first and foremost thing that you need is empathy. You need to be able to you do need to be able to walk in their shoes, you need in that moment you need to be able to empathise with their sadness, feel their sadness, but not not take it on as your own sadness so there has to be some some way of disentangling yourself, some objectivity about it.	Therapist	Empathy
	I:	So empathy up to a point, what else?		
Personal qualities	P:	Hmm reliability. So that the client knows you're always going to be there for them. And humanness really. And you need to be able to challenge your clients as well. In a positive way, helpful way, but not collude with them…we have to be able to dialogue, erm, and that has to be two way, erm, thinking about one patient who came to about four appointments with me and for the last two just refused to speak. Erm, and there was no possibility of us achieving anything.	Mutual	Trust (in therapist)
Personal qualities			Mutual	Willingness (to challenge and be challenged)
Barriers to recovery			Lack of active engagement	

Appendix 12.Template development audit process

Initial Template (06/01/2016)

1. **Initial session 'wants'**
    - 1.1. Therapist-specific
    - 1.2. Client-specific
    - 1.3. Mutual
2. **Defining 'recovery'**
    - 2.1. Cues (verbal and non-verbal)
    - 2.2. Service recovery
        - 2.2.1. Outcome measures
        - 2.2.2. Recovery rates
    - 2.3. Clinical recovery
        - 2.3.1. Symptom reduction
        - 2.3.2. Medication changes
3. **Meaning of 'recovery' to patients**
    - 3.1. Patient benchmarks
    - 3.2. Importance of recovery
        - 3.2.1. Symptom reduction
        - 3.2.2. Improved functioning
4. **Personal qualities beneficial for promoting recovery**
    - 4.1. Client
    - 4.2. Therapist
        - 4.2.1. Empathy
        - 4.2.2. Resilience
    - 4.3. Mutual

First Template Revisions (14/01/2016)

1. **Initial session 'wants'**
    1.1. Therapist-specific
        1.1.1. Psychoeducation
        1.1.2. Strategies
        1.1.3. Risk
    1.2. Client-specific
        1.2.1. Sense-making
        1.2.2. Agency
        1.2.3. 'Feeling better'
    1.3. Mutual
        1.3.1. Alliance and rapport
        1.3.2. Engagement
        1.3.3. Realism
2. **Defining 'recovery'**
    2.1. Complexity
    2.2. Therapy-specific cues
        2.2.1. Goal attainment
            2.2.1.1. Subjectivity
        2.2.2. Between-session work
    2.3. Service recovery
        2.3.1. Data set
        2.3.2. Recovery rates
    2.4. Clinical recovery
        2.4.1. Symptom changes/improved quality of life
            2.4.1.1. Self-reported changes

2.4.2. Increased agency

3. <u>Meaning of 'recovery' to patients</u>

3.1. Patient benchmarks

3.1.1. Goal attainment

3.1.2. 'Feeling better'

3.2. Importance of recovery

3.2.1. Symptom reduction

3.2.2. Enjoyment and functioning

3.2.3. Recovery 'buzz word'

4. <u>Personal qualities beneficial for promoting recovery</u>

4.1. Client

4.1.1. Engagement

4.1.2. Support networks

4.2. Therapist

4.2.1. Empathy

4.2.2. Flexibility

4.2.3. Reflection/curiosity

4.2.4. Acceptance

4.2.5. Caring

4.2.6. Awareness

4.3. Mutual

4.3.1. Hope(lessness)

4.3.2. Trust/faith

4.3.3. Willingness

4.3.4. Alliance

4.3.5. Resilience/strength

5. Misc. themes

5.1. Tracking change

5.2. Translating feelings into behaviours

5.3. Tension

5.4. Person-centred

5.5. Recovery journey

5.6. Investment

5.7. Metaphor

5.8. Stepped care

5.9. Managing expectations

6. Barriers to recovery

6.1. Lack of active engagement

6.2. Time

6.3. Difference

6.4. ‘Too much’ empathy

Second Template Revisions (18/01/2016)

1. **Initial session 'wants'**
    - 1.1. Therapist-specific
        - 1.1.1. Strategies (inc. risk and psychoeducation)
    - 1.2. Client-specific
        - 1.2.1. Sense-making
        - 1.2.2. Agency
        - 1.2.3. 'Feeling better'
    - 1.3. Mutual
        - 1.3.1. Alliance and rapport
        - 1.3.2. Engagement
        - 1.3.3. Realism
2. **Defining 'recovery'**
    - 2.1. Complexity
    - 2.2. Therapy-specific cues
        - 2.2.1. Goal attainment
            - 2.2.1.1. Subjectivity
        - 2.2.2. Between-session work
    - 2.3. Service recovery
        - 2.3.1. Data set
        - 2.3.2. Recovery rates
    - 2.4. Clinical recovery
        - 2.4.1. Symptom changes/improved quality of life
            - 2.4.1.1. Self-reported changes
        - 2.4.2. Increased agency

3. Meaning of ‘recovery’ to patients

3.1. Patient benchmarks

3.1.1. Goal attainment

3.1.2. ‘Feeling better’

3.2. Importance of recovery

3.2.1. Symptom reduction

3.2.2. Enjoyment and functioning

3.2.3. Recovery ‘buzz word’

4. Personal qualities beneficial for promoting recovery

4.1. Client

4.1.1. Engagement

4.1.2. Support networks

4.2. Therapist

4.2.1. Empathy

4.2.2. Flexibility

4.2.3. Reflection/curiosity

4.2.4. Acceptance

4.2.5. Caring

4.2.6. Awareness

4.3. Mutual

4.3.1. Hope(lessness)

4.3.2. Trust/faith

4.3.3. Willingness

4.3.4. Alliance

4.3.5. Resilience/strength

5. Misc. themes

5.1. Tracking change

5.2. Translating feelings into behaviours

5.3. Tension

5.4. Recovery journey

5.5. Investment

5.6. Metaphor

5.7. Stepped care

5.8. Managing expectations (inc. person-centred approach)

6. Barriers to recovery

6.1. Lack of active engagement

6.2. Time

6.3. Difference

6.4. 'Too much'/'too little' empathy

6.5. Misc. barriers

Third Template Revisions (25/01/2016)

1. **Initial session 'wants'**
    - 1.1. Therapist-specific
        - 1.1.1. Strategies (inc. risk and psychoeducation)
        - 1.1.2. Translating feelings into behaviours
        - 1.1.3. Managing expectations (inc. person-centred approach)
    - 1.2. Client-specific
        - 1.2.1. Sense-making
        - 1.2.2. Agency
        - 1.2.3. 'Feeling better'
    - 1.3. Mutual
        - 1.3.1. Alliance and rapport
        - 1.3.2. Engagement
        - 1.3.3. Realism
2. **Defining 'recovery'**
    - 2.1. Complexity
    - 2.2. Therapy-specific cues
        - 2.2.1. Goal attainment
            - 2.2.1.1. Subjectivity
        - 2.2.2. Between-session work
    - 2.3. Service recovery
        - 2.3.1. Data set
        - 2.3.2. Recovery rates
        - 2.3.3. Tracking change
        - 2.3.4. Tension
    - 2.4. Clinical recovery

2.4.1. Symptom changes/improved quality of life

2.4.1.1. Self-reported changes

2.4.1.2. Recovery journey (including metaphor)

2.4.2. Increased agency

3. <u>Meaning of 'recovery' to patients</u>

3.1. Patient benchmarks

3.1.1. Goal attainment

3.1.2. 'Feeling better'

3.2. Importance of recovery

3.2.1. Symptom reduction

3.2.2. Enjoyment and functioning

3.2.3. Recovery 'buzz word'

4. <u>Personal qualities beneficial for promoting recovery</u>

4.1. Client

4.1.1. Engagement

4.1.2. Support networks

4.2. Therapist

4.2.1. Empathy

4.2.2. Flexibility

4.2.3. Reflection/curiosity

4.2.4. Acceptance

4.2.5. Caring

4.2.6. Awareness (including stepped care)

4.3. Mutual

4.3.1. Hope(lessness)

4.3.2. Trust/faith

4.3.3. Willingness

4.3.4. Alliance

4.3.5. Investment

4.3.6. Resilience/strength

5. <u>Barriers to recovery</u>

5.1. Lack of active engagement

5.2. Time

5.3. Difference

5.4. ‘Too much’/’too little’ empathy

5.5. Misc. barriers

Fourth Template Revisions (07/02/2016)

1. **Initial session 'wants'**
    - 1.1. Therapist-specific
        - 1.1.1. Managing expectations
        - 1.1.2. Alliance and rapport
    - 1.2. Client-specific
        - 1.2.1. 'Feeling better'
2. **Defining 'recovery'**
    - 2.1. Complexity
    - 2.2. Therapy-specific cues
    - 2.3. Service recovery
        - 2.3.1. Tension
    - 2.4. Clinical recovery
        - 2.4.1. Symptom changes/improved quality of life
        - 2.4.2. Self-reported changes
        - 2.4.3. Recovery journey
3. **Meaning of 'recovery' to patients**
    - 3.1. Patient benchmark: 'feeling better'
    - 3.2. Importance of recovery
        - 3.2.1. Symptom reduction
        - 3.2.2. Recovery 'buzz word'
4. **Personal qualities beneficial for promoting recovery**
    - 4.1. Therapist
        - 4.1.1. Awareness
        - 4.1.2. Empathy
        - 4.1.3. Flexibility

4.2. Mutual

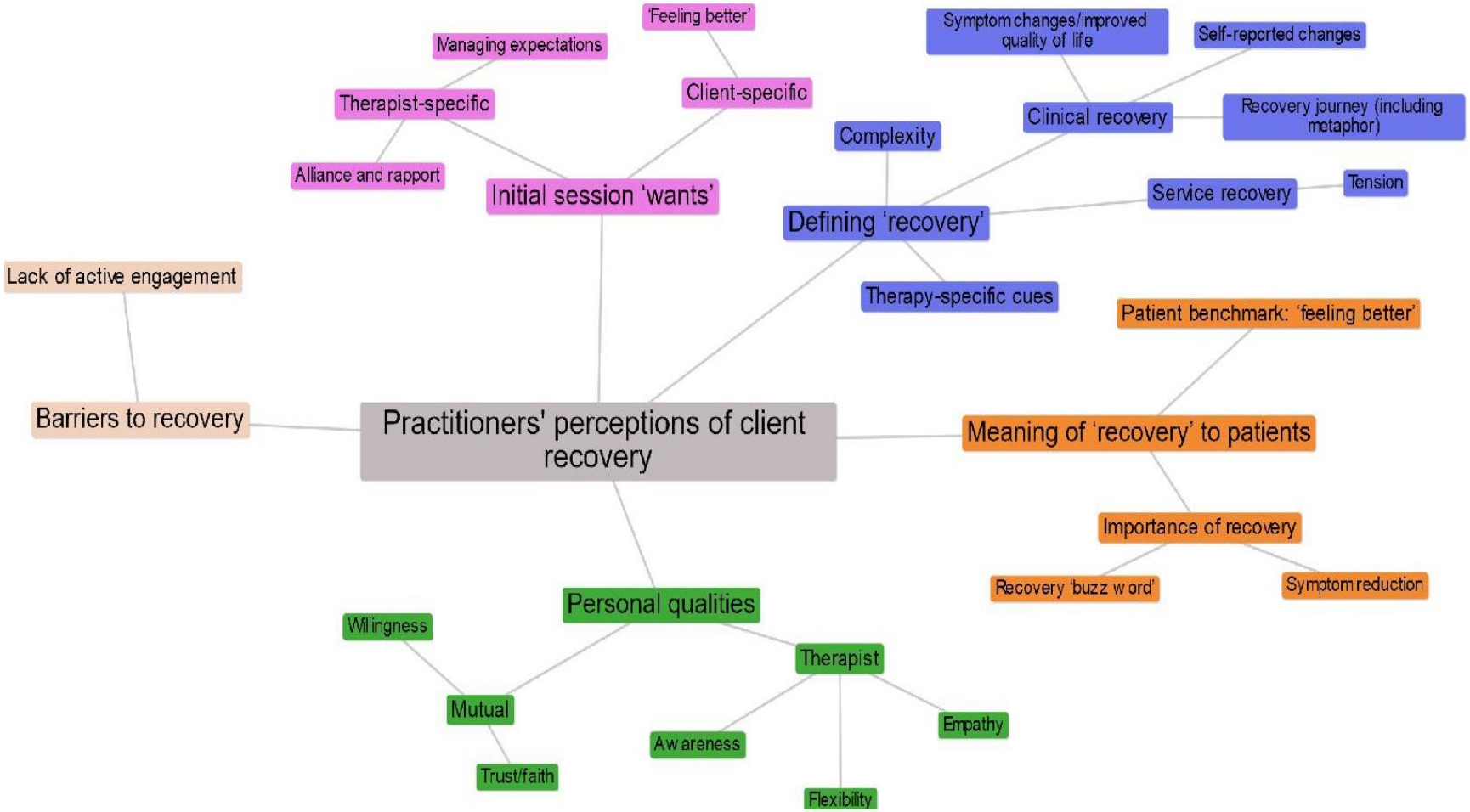
4.2.1. Trust/faith

4.2.2. Willingness

5. Barriers to recovery

5.1. Lack of active engagement

Appendix 13. Conceptual map of final template



Appendix 14.Distribution of participants across themes

		P1 CBT	P2 PWP	P3 CBT	P4 C	P5 C	P6 CBT	P7 PWP	P8 PWP	P9 CBT	P10 PWP	P11 CBT	P12 PWP	P13 C	P14 PWP	P15 C	P16 C	P17 C
Initial session 'wants'	Managing expectations		x	x	x	x	x	x	x	x	x		x	x	x	x	x	
	Alliance and rapport	x		x				x	x		x	x		x		x	x	
	'Feeling better'				x	x	x	x	x	x	x	x		x	x	x		x
Defining 'recovery'	Complexity	x	x	x	x	x	x	x	x	x	x		x	x		x		
	Therapy-specific cues	x	x	x	x	x	x	x		x	x		x	x	x	x		x
	Service recovery	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Tension	x	x	x		x	x		x	x	x	x	x	x	x	x	x	x
	Symptom changes/quality of life	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x
	Self-reported changes	x	x	x	x		x	x			x		x			x	x	x
	Recovery journey	x	x	x		x	x		x	x	x	x		x		x		x
Meaning of 'recovery' to patients	Patient benchmark: 'feeling better'	x		x	x	x	x		x	x	x	x	x	x	x	x	x	x
	Symptom reduction	x				x	x	x		x	x	x	x		x			x
	Recovery 'buzz word'			x					x	x		x		x	x	x		x
Personal qualities beneficial for promoting recovery	Awareness		x	x		x	x	x	x	x	x	x			x		x	
	Empathy	x			x	x	x	x	x	x			x	x		x	x	x
	Flexibility	x	x		x		x		x	x	x	x	x	x	x		x	
	Trust/faith	x	x	x	x				x			x		x				x
	Willingness	x	x						x	x		x	x	x	x	x		x
Barriers to recovery	Lack of active engagement		x	x		x	x	x	x	x	x	x		x		x		

*Note.*C=Counsellor; CBT=CBT Therapist; P = Participant; PWP=Psychological Wellbeing Practitioner.

Appendix 15. Results from Chi-squared tests for independence

Table 7. Chi-squared tests for independence: Resilience

Theme	N (%) of participants	χ^2	*P*
Managing Expectations		.73	.395
High	5 (35.71)		
Low	9 (64.29)		
Creating Rapport & Alliance		.03	.873
High	4 (44.44)		
Low	5 (55.56)		
Feeling Better'		.61	.435
High	7 (58.33)		
Low	5 (41.67)		
Complexity		.00	.947
High	6 (46.15)		
Low	7 (53.85)		
Therapy Specific Cues		.10	.752
High	6 (42.86)		
Low	8 (57.14)		
Service Recovery		.00	1.000
High	8 (47.06)		
Low	9 (52.94)		
Service Rec: Tension		.00	.975
High	7 (46.67)		
Low	8 (53.33)		
Clinical Rec: Symptom/QoL		.07	.791
High	7 (43.75)		
Low	9 (56.25)		
Clinical Rec: Self-report		.01	.913
High	5 (45.45)		
Low	6 (54.45)		
Clinical Rec: Journey		.61	.435
High	7 (58.33)		
Low	5 (41.67)		
Pt Benchmark: Feeling better		.24	.627
High	8 (53.33)		
Low	7 (46.67)		
Importance: Symptom Red.		.03	.854
High	5 (50.00)		
Low	5 (50.00)		
Importance: Rec. buzz word		.26	.612
High	5 (55.56)		
Low	4 (44.44)		
Awareness		.51	.476
High	4 (36.36)		
Low	7 (63.64)		
Empathy		.61	.435
High	7 (58.33)		
Low	5 (41.67)		
Flexibility		.04	.840
High	6 (50.00)		
Low	6 (50.00)		
Trust/Faith		.26	.612
High	5 (55.56)		
Low	4 (44.44)		
Willingness		.67	.414
High	6 (60.00)		
Low	4 (40.00)		
Lack of active engagement		.01	.913
High	5 (45.45)		
Low	6 (54.45)		

Table 8. Chi-squared tests for independence: Total empathy

Theme	N (%) of participants	χ^2	*P*
Managing Expectations		0.10	.752
High	6 (42.85)		
Low	8 (57.14)		
Creating Rapport & Alliance		0.26	.612
High	5 (55.56)		
Low	4 (44.44)		
Feeling Better'		0.14	.707
High	5 (41.67)		
Low	7 (58.33)		
Complexity		0.24	.625
High	7 (53.85)		
Low	6 (46.15)		
Therapy Specific Cues		0.05	.826
High	7 (50.00)		
Low	7 (50.00)		
Service Recovery		0.00	1.000
High	8 (47.06)		
Low	9 (52.94)		
Service Rec: Tension		0.30	.584
High	6 (40.00)		
Low	9 (60.00)		
Clinical Rec: Symptom/QoL		0.06	.814
High	8 (50.00)		
Low	8 (50.00)		
Clinical Rec: Self-report		0.01	.913
High	5 (45.45)		
Low	6 (54.55)		
Clinical Rec: Journey		0.14	.707
High	5 (41.67)		
Low	7 (58.33)		
Pt Benchmark: Feeling better		0.30	.584
High	6 (40.00)		
Low	9 (60.00)		
Importance: Symptom Red.		0.20	.653
High	4 (40.00)		
Low	6 (60.00)		
Importance: Rec. buzz word		0.69	.408
High	3 (33.33)		
Low	6 (66.67)		
Awareness		0.01	.913
High	5 (45.45)		
Low	6 (54.55)		
Empathy		0.91	.340
High	4 (33.33)		
Low	8 (66.67)		
Flexibility		0.04	.840
High	6 (50.00)		
Low	6 (50.00)		
Trust/Faith		0.26	.612
High	5 (55.56)		
Low	4 (44.44)		
Willingness		1.17	.279
High	3 (30.00)		
Low	7 (70.00)		
Lack of active engagement		0.51	.476
High	4 (36.36)		
Low	7 (63.64)		

Table 9. Chi-squared tests for independence: Affective empathy

Theme	N (%) of participants	χ^2	*P*
Managing Expectations		.10	.748
High	8 (57.14)		
Low	6 (42.86)		
Creating Rapport & Alliance		.64	.423
High	6 (66.67)		
Low	3 (33.33)		
Feeling Better'		.12	.729
High	7 (58.33)		
Low	5 (41.67)		
Complexity		.37	.541
High	8 (61.54)		
Low	5 (38.46)		
Therapy Specific Cues		.10	.748
High	8 (57.14)		
Low	6 (42.86)		
Service Recovery		.00	1.000
High	9 (52.94)		
Low	8 (47.06)		
Service Rec: Tension		.22	.642
High	7 (46.67)		
Low	8 (53.33)		
Clinical Rec: Symptom/QoL		.06	.802
High	9 (56.25)		
Low	7 (43.75)		
Clinical Rec: Self-report		.02	.904
High	6 (54.55)		
Low	5 (45.45)		
Clinical Rec: Journey		.05	.817
High	6 (50.00)		
Low	6 (50.00)		
Pt Benchmark: Feeling better		.00	.959
High	8 (53.33)		
Low	7 (46.67)		
Importance: Symptom Red.		.04	.849
High	5 (50.00)		
Low	5 (50.00)		
Importance: Rec. buzz word		.29	.593
High	4 (44.44)		
Low	5 (55.56)		
Awareness		.02	.904
High	6 (54.55)		
Low	5 (45.45)		
Empathy		.05	.817
High	6 (50.00)		
Low	6 (50.00)		
Flexibility		.66	.418
High	5 (41.67)		
Low	7 (58.33)		
Trust/Faith		.02	.894
High	5 (55.56)		
Low	4 (44.44)		
Willingness		.68	.410
High	4 (40.00)		
Low	6 (60.00)		
Lack of active engagement		.02	.904
High	6 (54.55)		
Low	5 (45.45)		

Table 10. Chi-squared tests for independence: Cognitive empathy

Theme	N (%) of participants	χ^2	*P*
Managing Expectations		.18	.676
High	5 (35.71)		
Low	9 (64.29)		
Creating Rapport & Alliance		.76	.382
High	5 (55.56)		
Low	4 (44.44)		
Feeling Better'		.39	.534
High	6 (50.00)		
Low	6 (50.00)		
Complexity		**4.23**	**.040***
High	9 (69.23)		
Low	4 (30.77)		
Therapy Specific Cues		.18	.676
High	5 (35.71)		
Low	9 (64.29)		
Service Recovery		.00	1.000
High	7 (41.18)		
Low	10 (58.82)		
Service Rec: Tension		.38	.536
High	5 (33.33)		
Low	10 (66.67)		
Clinical Rec: Symptom/QoL		.04	.835
High	7 (43.75)		
Low	9 (56.25)		
Clinical Rec: Self-report		.11	.745
High	4 (36.36)		
Low	7 (63.64)		
Clinical Rec: Journey		.30	.581
High	4 (33.33)		
Low	8 (66.67)		
Pt Benchmark: Feeling better		.01	.925
High	6 (40.00)		
Low	9 (60.00)		
Importance: Symptom Red.		.32	.572
High	5 (50.00)		
Low	5 (50.00)		
Importance: Rec. buzz word		.23	.631
High	3 (33.33)		
Low	6 (66.67)		
Awareness		.08	.773
High	5 (45.45)		
Low	6 (54.55)		
Empathy		.30	.581
High	4 (33.33)		
Low	8 (66.67)		
Flexibility		.39	.534
High	6 (50.00)		
Low	6 (50.00)		
Trust/Faith		.76	.382
High	5 (55.56)		
Low	4 (44.44)		
Willingness		.01	.939
High	4 (40.00)		
Low	6 (60.00)		
Lack of active engagement		.11	.745
High	4 (36.36)		
Low	7 (63.64)		

* Statistically significant at $p<.05$